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and Related Laws

November 1980 Edition

COMMITTEE ON FINANCE
UNITED STATES SENATE

ROBERT J. DOLE, *Chairman*

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PREFACE

Since the 92d Congress, numerous laws have been enacted amending the Social Security Act or otherwise directly affecting programs under that act. In order to provide a convenient reference to the Social Security Act as it has been amended by these various laws, this document has been prepared. It includes all of the titles of that act currently in force with all amendments up to October 31, 1980. Also included are the full text of the Federal-State Extended Unemployment Compensation Act, as amended, and pertinent excerpts from the Internal Revenue Code and from various public laws enacted since the 92d Congress.

This document is intended to supplement and not to replace the *Compilation of the Social Security Laws* which is prepared by the Social Security Administration and published from time to time as a document of the House of Representatives. The most recent edition of that *Compilation* was issued as House Document No. 93–117 (in 2 volumes) and contained the Social Security Act and related laws as amended through January 1, 1973. The *Compilation*, although not containing amendments after that date, does have several features not found in this current document. In particular, the *Compilation* has far more extensive footnotes, contains an index, and includes excerpts from numerous laws affecting social security programs which are not included in the current document.

It is expected that, as subsequent amendments to the Social Security Act and related laws are enacted or as changes are made through the operation of certain automatic provisions of existing law, appropriate revision pages will be printed from time to time.

This document has been prepared solely for convenient reference purposes. It does not have the effect of law.

Note: December revision pages update this edition through the end of the 96th Congress.

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eral homes remains unpaid, to such funeral home or funeral homes to the extent of such unpaid expenses, but only if (A) any person who assumed the responsibility for the payment of all or any part of such burial expenses files an application, prior to the expiration of two years after the date of death of such insured individual, requesting that such payment be made to such funeral home or funeral homes, or (B) at least 90 days have elapsed after the date of death of such insured individual and prior to the expiration of such 90 days no person has assumed responsibility for the payment of any such burial expenses;

(2) if all of the burial expenses of such insured individual which were incurred by or through a funeral home or funeral homes have been paid (including payments made under clause (1)), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such burial expenses;

(3) if the body of such insured individual is not available for burial but expenses were incurred with respect to such individual in connection with a memorial service, a memorial marker, a site for the marker, or any other item of a kind for which expenses are customarily incurred in connection with a death and such expenses have been paid, to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid such expenses; or

(4) if any part of the amount payable under this subsection remains after payments have been made pursuant to clauses (1), (2), and (3), to any person or persons, equitably entitled thereto, to the extent and in the proportions that he or they shall have paid other expenses in connection with the burial of such insured individual, in the following order of priority: (A) expenses of opening and closing the grave of such insured individual, (B) expenses of providing the burial plot of such insured individual, and (C) any remaining expenses in connection with the burial of such insured individual.

No payment (except a payment authorized pursuant to clause (1) (A) of the preceding sentence) shall be made to any person under this subsection unless application therefor shall have been filed, by or on behalf of such person (whether or not legally competent), prior to the expiration of two years after the date of death of such insured individual, or unless such person was entitled to wife's or husband's insurance benefits, on the basis of the wages and self-employment income of such insured individual, for the month preceding the month in which such individual died. In the case of any individual who died out-

side the forty-eight States and the District of Columbia after December 1953 and before January 1, 1957, whose death occurred while he was in the active military or naval service of the United States, and who is returned to any of such States, the District of Columbia, Alaska, Hawaii, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa for interment or reinterment, the provisions of the preceding sentence shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment. In the case of any individual who died outside the fifty States and the District of Columbia after December 1956 while he was performing service, as a member of a uniformed service, to which the provisions of section 210(l)(1) are applicable, and who is returned to any State or to any Territory or possession of the United States, for interment or reinterment, the provisions of the third sentence of this subsection shall not prevent payment to any person under the second sentence of this subsection if application for a lump-sum death payment with respect to such deceased individual is filed by or on behalf of such person (whether or not legally competent) prior to the expiration of two years after the date of such interment or reinterment.

Application for Monthly Insurance Benefits

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

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

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

Any benefit under this title for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing of such application, the Secretary has certified for payment for such prior month.[1]

[1] Par. (1) was amended by sec. 332(a) of P.L. 95–216 and, effective Mar. 1, 1981, by sec. 1011 of P.L. 96–499.

(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and no request under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced

be payable or certified for payment for such representation except as provided in this paragraph.

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.

Assignment

Sec. 207. The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

Penalties

Sec. 208. Whoever—

(a) for the purpose of causing an increase in any payment authorized to be made under this title, or for the purpose of causing any payment to be made where no payment is authorized under this title, shall make or cause to be made any false statement or representation (including any false statement or representation in connection with any matter arising under subchapter E of chapter 1, or subchapter A or E of chapter 9 of the Internal Revenue Code of 1939, or chapter 2 or 21 or subtitle F of the Internal Revenue Code of 1954) as to—

(1) whether wages were paid or received for employment (as said terms are defined in this title and the Internal Revenue Code), or the amount of wages or the period during which paid or the person to whom paid; or

(2) whether net earnings from self-employment (as such term is defined in this title and in the Internal Revenue Code) were derived, or as to the amount of such net earnings or the period during which or the person by whom derived; or

(3) whether a person entitled to benefits under this title had earnings in or for a particular period (as determined under section 203(f) of this title for purposes of deductions from benefits), or as to the amount thereof; or

(b) makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this title; or

(c) at any time makes or causes to be made any false statement or representation of a material fact for use in determining rights to payment under this title; or

(d) having knowledge of the occurrence of any event affecting (1) his initial or continued right to any payment under this title, or (2) the initial or continued right to any payment of any other individual in whose behalf he has applied for or is receiving such payment, conceals or fails to disclose such event with an intent fraudulently to secure payment either in a greater amount than is due or when no payment is authorized; or

(e) having made application to receive payment under this title for the use and benefit of another and having received such a payment, knowingly and willfully converts such a payment, or any part thereof, to a use other than for the use and benefit of such other person; or

(f) willfully, knowingly, and with intent to deceive the Secretary as to his true identity (or the true identity of any other person) furnishes or causes to be furnished false information to the Secretary with respect to any information required by the Secretary in connection with the establishment and maintenance of the records provided for in section 205(c)(2); or

(g) for the purpose of causing an increase in any payment authorized under this title (or any other program financed in whole or in part from Federal funds), or for the purpose of causing a payment under this title (or any such other program) to be made when no payment is authorized thereunder, or for the purpose of obtaining (for himself or any other person) any payment or any other benefit to which he (or such other person) is not entitled, or for any other purpose—

(1) willfully, knowingly, and with intent to deceive, uses a social security account number, assigned by the Secretary (in the exercise of his authority under section 205(c)(2) to establish and maintain records) on the basis of false information furnished to the Secretary by him or by any other person; or

(2) with intent to deceive, falsely represents a number to be the social security account number assigned by the Secretary to him or to another person, when in fact such number is not the social security account number assigned by the Secretary to him or to such other person; or [1]

(h) discloses, uses, or compels the disclosure of the social security number of any person in violation of the laws of the United States; [2]

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

[1] Subsec. (g) was amended by secs. 1211(a) and (d)(2) of P.L. 94-455.
[2] Subsec. (h) was added by sec. 1211(d)(1) of P.L. 94-455.

at the time of any such payment after 1962, is a plan described in section 403(a) of the Internal Revenue Code of 1954, or (4) under or to a bond purchase plan which, at the time of any such payment after 1962, is a qualified bond purchase plan described in section 405(a) of the Internal Revenue Code of 1954;

(f) The payment by an employer (without deduction from the remuneration of the employee)—

(1) of the tax imposed upon an employee under section 3101 of the Internal Revenue Code of 1954, or

(2) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor; [1]

(g)(1) Remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(2) Cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this paragraph, the term "domestic service in a private home of the employer" does not include service described in section 210(f)(5);

(3) Cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this paragraph, the term "service not in the course of the employer's trade or business" does not include domestic service in a private home of the employer and does not include service described in section 210(f)(5); [2]

(h)(1) Remuneration paid in any medium other than cash for agricultural labor;

(2) Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless (A) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or (B) the employee performs agricultural labor for the employer on twenty days or more during such year for cash remuneration computed on a time basis;

(i) Any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62 if he did not work for the employer in the period for which such payment is made. As used in this subsection, the term "sick pay" includes remuneration for service in the employ of a State, a political subdivision (as defined in section 218(b)(2)) of a State, or an instrumentality of two or more

[1] Subsec. (f) was amended by sec. 1141 of P.L. 96-499. (See excerpt from that public law for exception in the case of certain State and local governments.)
[2] Par. (3) was amended by sec. 353(a)(1) and (2) of P.L. 95-216.

States, paid to an employee thereof for a period during which he was absent from work because of sickness;

(j) Remuneration paid by an employer in any year to an employee for service described in section 210(j)(3)(C) (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;[1]

(k) Remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217 of the Internal Revenue Code of 1954;

(l)(1) Tips paid in any medium other than cash;

(2) Cash tips received by an employee in any calendar month in the course of his employment by an employer unless the amount of such cash tips is $20 or more;

(m) Any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(1) upon or after the termination of an employee's employment relationship because of (A) death, (B) retirement for disability, or (C) retirement after attaining an age specified in the plan referred to in paragraph (2) or in a pension plan of the employer, and

(2) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents),

other than any such payment or series of payments which would have been paid if the employee's employment relationship had not been so terminated;

(n) Any payment made by an employer to a survivor or the estate of a former employee after the calendar year in which such employee died;

(o) Any payment made by an employer to an employee, if at the time such payment is made such employee is entitled to disability insurance benefits under section 223(a) and such entitlement commenced prior to the calendar year in which such payment is made, and if such employee did not perform any services for such employer during the period for which such payment is made; or

(p) Remuneration paid by an organization exempt from income tax under section 501 of the Internal Revenue Code of 1954 in any calendar year to an employee for service rendered in the employ of such organization, if the remuneration paid in such year by the organization to the employee for such service is less than $100.[2]

[1] Subsection (j) was amended by sec. 351(a)(1) and (2) of Public Law 95-216.
[2] Subsection (p) was added by sec. 351(a)(3)(A) of Public Law 95-216.

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and home health services (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and[1]

(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

(d) For purposes of this section, the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 7(d) of the Railroad Retirement Act of 1974. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 7(d) of the Railroad Retirement Act of 1974.

[1] Par. (1) was amended, with respect to services furnished on or after July 1, 1981, by sec. 930(q) of P.L. 96-499.

(e)(1) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of widows and widowers described in paragraph (2)(A)(iii) thereof—

(A) the term "age 60" in sections 202(e)(1)(B)(ii), 202(e)(5), 202(f)(1)(B)(ii), and 202(f)(6) shall be deemed to read "age 65"; and

(B) the phrase "before she attained age 60" in the matter following subparagraph (F) of section 202(e)(1) and the phrase "before he attained age 60" in the matter following subparagraph (F) of section 202(f)(1) shall each be deemed to read "based on a disability".[1]

(2) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual under age 65 who is entitled to benefits under section 202, and who was entitled to widow's insurance benefits or widower's insurance benefits based on disability for the month before the first month in which such individual was so entitled to old-age insurance benefits (but ceased to be entitled to such widow's or widower's insurance benefits upon becoming entitled to such old-age insurance benefits), such individual shall be deemed to have continued to be entitled to such widow's insurance benefits or widower's insurance benefits for and after such first month.

(3) For purposes of determining entitlement to hospital insurance benefits under subsection (b) any disabled widow age 50 or older who is entitled to mother's insurance benefits (and who would have been entitled to widow's insurance benefits by reason of disability if she had filed for such widow's benefits) shall, upon application, for such hospital insurance benefits be deemed to have filed for such widow's benefits and shall, upon furnishing proof of such disability prior to

[1] Subpar. (B) was amended by sec. 334(d)(4)(B) of P.L. 95–216.

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Part A—Aid to Families With Dependent Children

Appropriation

Section 401. For the purpose of encouraging the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services, as far as practicable under the conditions in such State, to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for aid and services to needy families with children.

State Plans for Aid and Services to Needy Families With Children

Sec. 402. (a) A State plan for aid and services to needy families with children must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

[1] This table of contents does not appear in the law.

(2) provide for financial participation by the State;

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

that, if the relative with whom a child is living is found to be ineligible because of failure to comply with the requirements of subparagraphs (A) and (B) of this paragraph, any aid for which such child is eligible will be provided in the form of protective payments as described in section 406(b)(2) (without regard to subparagraphs (A) through (E) of such section);[1,2]

(27) provide that the State has in effect a plan approved under part D and operate a child support program in conformity with such plan;[1,3]

(28) provide that, in determining the amount of aid to which an eligible family is entitled, any portion of the amounts collected in any particular month as child support pursuant to a plan approved under part D, and retained by the State under section 457, which (under the State plan approved under this part as in effect both during July 1975 and during that particular month) would not have caused a reduction in the amount of aid paid to the family if such amounts had been paid directly to the family, shall be added to the amount of aid otherwise payable to such family under the State plan approved under this part;[4]

(29) effective October 1, 1979, provide that wage information available from the Social Security Administration under the provisions of section 411 of this Act, and wage information available (under the provisions of section 3304(a)(16) of the Federal Unemployment Tax Act) from agencies administering State unemployment compensation laws, shall be requested and utilized to the extent permitted under the provisions of such sections; except that the State shall not be required to request such information from the Social Security Administration where such information is available from the agency administering the State unemployment compensation laws;[5] and

(30) at the option of the State, provide for the establishment and operation, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under subsection (d), of an automated statewide management information system designed effectively and efficiently, to assist management in the administration of the State plan for aid to families with dependent children approved under this part, so as (A) to control and account for (i) all the factors in the total eligibility determination process under such plan for aid (including but not limited to (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses, and mailing addresses (including postal ZIP

[1] Secs. 402(a)(26) and 402(a)(27) were added by P.L. 93-647.

[2] Sec. 402(a)(26) was amended by P.L. 94-88. See secs. 201(a), 201(b), and 208(d) of P.L. 94-88 printed in this document on pp. 765 and 766.

[3] Sec. 402(a)(27) was amended by P.L. 94-88 and by sec. 6(f)(1) of P.L. 96-473. See also sec. 201(a) of P.L. 94-88.

[4] Sec. 402(a)(28) added by P.L. 94-88.

[5] Par. (29) was added by sec. 403(c) of P.L. 95-216 and was amended by sec. 6(f)(2) of P.L. 96-473.

codes), of all applicants and recipients of such aid and the relative with whom any child who is such an applicant or recipient is living) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether an individual is or has been receiving benefits from more than one jurisdiction, (II) checking records of applicants and recipients of such aid on a periodic basis with other agencies, both intra- and inter-State, for determination and verification of eligibility and payment pursuant to requirements imposed by other provisions of this Act), (ii) the costs, quality, and delivery of funds and services furnished to applicants for and recipients of such aid, (B) to notify the appropriate officials of child support, food stamp, social service, and medical assistance programs approved under title XIX whenever the case becomes ineligible or the amount of aid or services is changed, and (C) to provide for security against unauthorized access to, or use of, the data in such system.[1]

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes as a condition of eligibility for aid to families with dependent children a residence requirement which denies aid with respect to any child residing in the State (1) who has resided in the State for one year immediately preceding the application for such aid, or (2) who was born within one year immediately preceding the application, if the parent or other relative with whom the child is living has resided in the State for one year immediately preceding the birth.

(c) The Secretary shall, on the basis of his review of the reports received from the States under clause (15) of subsection (a), compile such data as he believes necessary and from time to time publish his findings as to the effectiveness of the programs developed and administered by the States under such clause. The Secretary shall annually report to the Congress (with the first such report being made on or before July 1, 1970) on the programs developed and administered by each State under such clause (15).

(d)(1) For purposes of paragraphs (7) and (8) of subsection (a), any refund of Federal income taxes made by reason of section 43 of the Internal Revenue Code of 1954 (relating to earned income credit) and any payment made by an employer under section 3507 of such Code (relating to advance payment of earned income credit) shall be considered earned income.

(2) In any case in which such advance payments for a taxable year made by all employers to an individual under section 3507 of such Code exceed the amount of such individual's earned income credit allowable under section 43 of such Code for such year, so that such

[1] Subpar. (30) was added by sec. 406 of P.L. 96-265 effective July 1, 1981.

(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 402 (a) to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(b) No payment to which a State is otherwise entitled under this title for any period before September 1, 1962, shall be withheld by reason of any action taken pursuant to a State statute which requires that aid be denied under the State plan approved under this part with respect to a child because of the conditions in the home in which the child resides; nor shall any such payment be withheld for any period beginning on or after such date by reason of any action taken pursuant to such a statute if provision is otherwise made pursuant to a State statute for adequate care and assistance with respect to such child.

(c) No State shall be found, prior to January 1, 1977, to have failed substantially to comply with the requirements of section 402 (a)(27) if, in the judgment of the Secretary, such State is making a good faith effort to implement the program required by such section.

(d) After December 31, 1976, in the case of any State which is found to have failed substantially to comply with the requirements of section 402(a)(27), the reduction in any amount payable to such State required to be imposed under section 403(h) shall be imposed in lieu of any reduction, with respect to such failure, which would otherwise be required to be imposed under this section.

Use of Payments for Benefit of Child

Sec. 405. Whenever the State agency has reason to believe that any payments of aid to families with dependent children made with respect to a child are not being or may not be used in the best interests of the child, the State agency may provide for such counseling and guidance services with respect to the use of such payments and the management of other funds by the relative receiving such payments as it deems advisable in order to assure use of such payments in the best interests of such child, and may provide for advising such relative that continued failure to so use such payments will result in substitution therefor of protective payments as provided under section 406 (b)(2), or in seeking appointment of a guardian or legal representa-

tive as provided in section 1111, or in the imposition of criminal or civil penalties authorized under State law if it is determined by a court of competent jurisdiction that such relative is not using or has not used for the benefit of the child any such payments made for that purpose; and the provision of such services or advice by the State agency (or the taking of the action specified in such advice) shall not serve as a basis for withholding funds from such State under section 404 and shall not prevent such payments with respect to such child from being considered aid to families with dependent children.

Definitions

Sec. 406. When used in this part—

(a) The term "dependent child" means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece in a place of residence maintained by one or more of such relatives as his or their own home, and (2) who is (A) under the age of eighteen, or (B) at the option of the State, under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school, college, or university, or regularly attending a course of vocational or technical training designed to fit him for gainful employment, or (C) at the option of the State, under the age of twenty-one and (as determined by the State in accordance with standards prescribed by the Secretary) a student regularly attending a school in grade twelve or below or regularly attending a course of vocational or technical training, other than a course provided by or through a college or university, designed to fit him for gainful employment; [1]

(b) The term "aid to families with dependent children" means money payments with respect to, or (if provided in or after the third month before the month in which the recipient makes application for aid) medical care in behalf of or any type of remedial care recognized under State law in behalf of, a dependent child or dependent children, and includes (1) money payments or medical care or any type of remedial care recognized under State law to meet the needs of the relative with whom any dependent child is living (and the spouse of such relative if living with him and if such relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent or is a dependent child under section 407), and (2) payments with respect to any dependent child (including payments to meet the needs of the relative, and the relative's

[1] Clause (2) was amended by sec. 4 of P.L. 96-611.

spouse, with whom such child is living, and the needs of any other individual living in the same home if such needs are taken into account in making the determination under section 402(a)(7)) which do not meet the preceding requirements of this subsection but which would meet such requirements except that such payments are made to another

individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of such child or relative, or are made on behalf of such child or relative directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such child, relative, or other individual, but only with respect to a State whose State plan approval under section 402 includes provision for—

(A) determination by the State agency that the relative of the child with respect to whom such payments are made has such inability to manage funds that making payments to him would be contrary to the welfare of the child and, therefore, it is necessary to provide such aid with respect to such child and relative through payments described in this clause (2);

(B) undertaking and continuing special efforts to develop greater ability on the part of the relative to manage funds in such manner as to protect the welfare of the family;

(C) periodic review by such State agency of the determination under clause (A) to ascertain whether conditions justifying such determination still exist, with provision for termination of such payments if they do not and for seeking judicial appointment of a guardian or other legal representative, as described in section 1111, if and when it appears that the need for such payments is continuing, or is likely to continue, beyond a period specified by the Secretary;

(D) aid in the form of foster home care in behalf of children described in section 408(a); and

(E) opportunity for a fair hearing before the State agency on the determination referred to in clause (A) for any individual with respect to whom it is made.

Payments with respect to a dependent child which are intended to enable the recipient to pay for specific goods, services, or items recognized by the State agency as a part of the child's need under the State plan may (in the discretion of the State or local agency administering the plan in the political subdivision) be made, pursuant to a determination referred to in clause (2)(A), in the form of checks drawn jointly to the order of the recipient and the person furnishing such goods, services, or items and negotiable only upon endorsement by both such recipient and such person; and payments so made shall be considered for all of the purposes of this part to be payments described in clause (2). Whenever payments with respect to a dependent child are made in the manner described in clause (2) (including payments described in the preceding sentence), a statement of the specific reasons for making such payments in that manner (on which the determination under clause (2)(A) was based) shall be placed

(A) in establishing paternity, if necessary,

(B) in locating an absent parent residing in the State (whether or not permanently) against whom any action is being taken under a program established under a plan approved under this part in another State,

(C) in securing compliance by an absent parent residing in such State (whether or not permanently) with an order issued by a court of competent jurisdiction against such parent for the support and maintenance of a child or children of such parent with respect to whom aid is being provided under the plan of such other State, and

(D) in carrying out other functions required under a plan approved under this part;

(10) provide that the State will maintain a full record of collections and disbursements made under the plan and have an adequate reporting system;

(11) provide that amounts collected as child support shall be distributed as provided in section 457;

(12) provide that any payment required to be made under section 456 or 457 to a family shall be made to the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children;

(13) provide that the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating absent parents, establishing paternity, obtaining support orders, and collecting support payments;

(14) comply with such bonding requirements, for employees who receive, disburse, handle, or have access to, cash, as the Secretary shall by regulations prescribe; [1]

(15) maintain methods of administration which are designed to assure that persons responsible for handling cash receipts shall not participate in accounting or operating functions which would permit them to conceal in the accounting records the misuse of cash receipts (except that the Secretary shall by regulations provide for exceptions to this requirement in the case of sparsely populated areas where the hiring of unreasonable additional staff would otherwise be necessary); [1]

(16) provide, at the option of the State, for the establishment, in accordance with an (initial and annually updated) advance automatic data processing planning document approved under section 452(d), of an automatic data processing and information retrieval system designed effectively and efficiently to assist management in the administration of the State plan, in the State and localities thereof, so as (A) to control, account for, and monitor

[1] Subpars. (14) and (15) were added by sec. 502(a) of P.L. 95-30.

(i) all the factors in the child support enforcement collection and paternity determination process under such plan (including, but not limited to, (I) identifiable correlation factors (such as social security numbers, names, dates of birth, home addresses and mailing addresses (including postal ZIP codes) of any individual with respect to whom child support obligations are sought to be established or enforced and with respect to any person to whom such support obligations are owing) to assure sufficient compatibility among the systems of different jurisdictions to permit periodic screening to determine whether such individual is paying or is obligated to pay child support in more than one jurisdiction, (II) checking of records of such individuals on a periodic basis with Federal, intra- and inter-State, and local agencies, (III) maintaining the data necessary to meet the Federal reporting requirements on a timely basis, and (IV) delinquency and enforcement activities), (ii) the collection and distribution of support payments (both intra- and inter-State), the determination, collection and distribution, of incentive payments both inter- and intra-State, and the maintenance of accounts receivable on all amounts owed, collected and distributed, and (iii) the costs of all services rendered, either directly or by interfacing with State financial management and expenditure information, (B) to provide interface with records of the State's aid to families with dependent children program in order to determine if a collection of a support payment causes a change affecting eligibility for or the amount of aid under such program, (C) to provide for security against unauthorized access to, or use of, the data in such system, and (D) to provide management information on all cases under the State plan from initial referral or application through collection and enforcement; and [1]

(17) in the case of a State which has in effect an agreement with the Secretary entered into pursuant to section 463 for the use of the Parent Locator Service established under section 453, to accept and transmit to the Secretary requests for information authorized under the provisions of the agreement to be furnished by such Service to authorized persons, and to impose and collect (in accordance with regulations of the Secretary) a fee sufficient to cover the costs to the State and to the Secretary incurred by reason of such requests, to transmit to the Secretary from time to time (in accordance with such regulations) so much of the fees collected as are attributable to such costs to the Secretary so incurred, and during the period that such agreement is in effect, otherwise to comply with such agreement and regulations of the Secretary with respect thereto.[2]

[1] Par. (16) was added by sec. 405 of P.L. 96-265 effective July 1, 1981.

[2] Par. (17) was added by sec. 9(a) of P.L. 96-611.

Payments to States

Sec. 455. (a) From the sums appropriated therefor, the Secretary shall pay to each State for each quarter, beginning with the quarter commencing July 1, 1975, an amount—

(1) equal to 75 percent of the total amounts expended by such State during such quarter for the operation of the plan approved under section 454,

(2) equal to 50 percent of the total amounts expended by such State during such quarter for the operation of a plan which meets the conditions of section 454 except as is provided by a waiver by the Secretary which is granted pursuant to specific authority set forth in the law, and

(3) equal to 90 percent (rather than the percent specified in clause (1) or (2)) of so much of the sums expended during such quarter as are attributable to the planning, design, development, installation or enhancement of an automatic data processing and information retrieval system which the Secretary finds meets the requirements specified in section 454(16);

except that no amount shall be paid to any State on account of amounts expended to carry out an agreement which it has entered into pursuant to section 463.[1]

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

(2) Subject to subsection (d), the Secretary shall then pay, in such installments as he may determine, to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.[2]

[1] Sec. 455(a) was amended by secs. 201(c) and 205 of P.L. 94–88, by sec. 3 of P.L. 95–365, by sec. 4 of P.L. 95–59, by sec. 2 of P.L. 96–178 (as amended by sec. 301 of P.L. 96–272) and (effective July 1, 1981) by sec. 405 of P.L. 96–265. Subsec. (a) was also amended by sec. 9(c) of P.L. 96–611. See also sec. 308 of P.L. 94–566 and P.L. 95–482 (continuing resolution).

[2] Sec. 455(b) added by P.L. 94–88 and amended by sec. 407 of P.L. 96–265. See also sec. 206 of P.L. 94–88 (p. 766 of this document).

(c)(1) Subject to paragraph (2), there shall be included, in determining amounts expended by a State during any quarter for the operation of the plan approved under section 454, so much of the expenditures of courts of such State and its political subdivisions (excluding expenditures for or in connection with judges and other individuals making judicial determinations, but not excluding expenditures for or in connection with their administrative and support personnel) as are attributable to the performance of services which are directly related to, and clearly identifiable with, the operation of such plan.

(2) The aggregate amount of the expenditures which are included pursuant to paragraph (1) for the quarters in any calendar year shall be reduced (but not below zero) by the total amount of expenditures described in paragraph (1) which were made by the State for the 12-month period beginning January 1, 1978.

(3) The State agency may, if the law (or procedures established thereunder) of the State so provides, pay so much of the amount it receives under subsection (a) for any quarter as is payable by reason of the provisions of this subsection directly to the courts of the State (or political subdivisions thereof) furnishing the services on account of which the payment is payable.[1]

(d) Notwithstanding any other provision of law, no amount shall be paid to any State under this section for any quarter, prior to the close of such quarter, unless for the period consisting of all prior quarters for which payment is authorized to be made to such State under subsection (a), there shall have been submitted by the State to the Secretary, with respect to each quarter in such period (other than the last two quarters in such period), a full and complete report (in such form and manner and containing such information as the Secretary shall prescribe or require) as to the amount of child support collected and disbursed and all expenditures with respect to which payment is authorized under subsection (a).[2]

Support Obligations

Sec. 456. (a) The support rights assigned to the State under section 402(a)(26) shall constitute an obligation owed to such State by the individual responsible for providing such support. Such obligation shall be deemed for collection purposes to be collectible under all applicable State and local processes.

(1) The amount of such obligation shall be—

(A) the amount specified in a court order which covers the assigned support rights, or

(B) if there is no court order, an amount determined by

[1] Subsec. (c) was added by sec. 404 of P.L. 96–265.

[2] Subsec. (d) was added by sec. 407 of P.L. 96–265 effective Jan. 1, 1981.

the State in accordance with a formula approved by the Secretary, and

(2) Any amounts collected from an absent parent under the plan shall reduce, dollar for dollar, the amount of his obligation under paragraphs (1)(A) and (B).

(b) [Repealed].[3]

Distribution of Proceeds

Sec. 457.[4] (a) The amounts collected as child support by a State pursuant to a plan approved under this part during the 15 months beginning July 1, 1975, shall be distributed as follows:

(1) 40 per centum of the first $50 of such amounts as are collected periodically which represent monthly support payments shall be paid to the family without any decrease in the amount paid as assistance to such family during such month;

(2) such amounts as are collected periodically which are in excess of any amount paid to the family under paragraph (1) which represent monthly support payments shall be retained by the State to reimburse it for assistance payments to the family during such period (with appropriate reimbursement of the

[3] Subsec. 456(b) repealed by sec. 328 of P.L. 95–598 effective Nov. 6, 1978.
[4] See sec. 402(a)(28).

not limited to, severance pay, sick pay, and incentive pay, but does not include awards for making suggestions, or

(2) periodic benefits (including a periodic benefit as defined in section 228(h)(3) of this Act) or other payments to such individual under the insurance system established by title II of this Act or any other system or fund established by the United States (as defined in subsection (a)) which provides for the payment of pensions, retirement or retired pay, annuities, dependents or survivors' benefits, or similar amounts payable on account of personal services performed by himself or any other individual (not including any payment as compensation for death under any Federal program, any payment under any Federal program established to provide "black lung" benefits, any payment by the Veterans' Administration as pension, or any payments by the Veterans' Administration as compensation for a service-connected disability or death, except any compensation paid by the Veterans' Administration to a former member of the Armed Forces who is in receipt of retired or retainer pay if such former member has waived a portion of his retired pay in order to receive such compensation), and does not consist of amounts paid, by way of reimbursement or otherwise, to such individual by his employer to defray expenses incurred by such individual in carrying out duties associated with his employment.

(g) In determining the amount of any moneys due from, or payable by, the United States to any individual, there shall be excluded amounts which—

(1) are owed by such individual to the United States,

(2) are required by law to be, and are, deducted from the remuneration or other payment involved, including but not limited to, Federal employment taxes, and fines and forfeitures ordered by court-martial,

(3) are properly withheld for Federal, State, or local income tax purposes, if the withholding of such amounts is authorized or required by law and if amounts withheld are not greater than would be the case if such individual claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1954 may be permitted only when such individual presents evidence of a tax obligation which supports the additional withholding),

(4) are deducted as health insurance premiums,

(5) are deducted as normal retirement contributions (not including amounts deducted for supplementary coverage), or

(6) are deducted as normal life insurance premiums from salary or other remuneration for employment (not including amounts deducted for supplementary coverage).

Use of Federal Parent Locator Service in Connection With the Enforcement or Determination of Child Custody and in Cases of Parental Kidnaping of a Child

SEC. 463. (a) The Secretary shall enter into an agreement with any State which is able and willing to do so, under which the services of the Parent Locator Service established under section 453 shall be made available to such State for the purpose of determining the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody determination.

(b) An agreement entered into under this section shall provide that the State agency described in section 454 will, under procedures prescribed by the Secretary in regulations, receive and transmit to the Secretary requests from authorized persons for information as to (or useful in determining) the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody determination.

(c) Information authorized to be provided by the Secretary under this section shall be subject to the same conditions with respect to disclosure as information authorized to be provided under section 453, and a request for information by the Secretary under this section shall be considered to be a request for information under section 453 which is authorized to be provided under such section. Only information as to the most recent address and place of employment of any absent parent or child shall be provided under this section.

(d) For purposes of this section—

(1) the term "custody determination" means a judgment, decree, or other order of a court providing for the custody or visitation of a child, and includes permanent and temporary orders, and initial orders and modification;

(2) the term "authorized person" means—

(A) any agent or attorney of any State having an agreement under this section, who has the duty or authority under the law of such State to enforce a child custody determination;

(B) any court having jurisdiction to make or enforce such a child custody determination, or any agent of such court; and

(C) any agent or attorney of the United States, or of a State having an agreement under this section, who has the duty or authority to investigate, enforce, or bring a prosecution with respect to the unlawful taking or restraint of a child.[1]

[1] Sec. 463 was added by sec. 9(b) of P.L. 96–611.

Part E—Federal Payments for Foster Care and Adoption Assistance [1]

Purpose: Appropriation

Sec. 470. For the purpose of enabling each State to provide, in appropriate cases, foster care and adoption assistance for children who otherwise would be eligible for assistance under the State's plan approved under part A (or, in the case of adoption assistance, would be eligible for benefits under title XVI), there are authorized to be appropriated for each fiscal year (commencing with the fiscal year which begins October 1, 1980) such sums as may be necessary to carry out the provisions of this part. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans under this part.

State Plan for Foster Care and Adoption Assistance

Sec. 471. (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

(1) provides for foster care maintenance payments in accordance with section 472 and for adoption assistance payments in accordance with section 473;

(2) provides that the State agency responsible for administering the program authorized by part B of this title shall administer, or supervise the administration of, the program authorized by this part;

(3) provides that the plan shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title, under title XX of this Act, and under any other appropriate provision of Federal law;

(5) provides that the State will, in the administration of its programs under this part, use such methods relating to the establishment and maintenance of personnel standards on a merit basis as are found by the Secretary to be necessary for the proper and efficient operation of the programs, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods;

(6) provides that the State agency referred to in paragraph (2) (hereinafter in this part referred to as the "State agency") will make such reports, in such form and containing such information as the Secretary may from time to time require, and com-

[1] Pt. E was added by sec. 101 of P.L. 96–272.

(D) In determining the number of children receiving aid for which Federal financial participation is authorized in payments under section 408 or under this part, for any fiscal year, with respect to any State and with respect to the national average for purposes of subparagraphs (B) and (C), there shall be included those children with respect to whom foster care maintenance payments were not made under section 408 or this part (though they were otherwise eligible for such payments) solely because their foster care was provided by related persons. In the event that there is a dispute between any State and the Secretary as to the number of such children (with respect to whom foster care maintenance payments were not made) for any fiscal year, then until the beginning of the fiscal year immediately following the fiscal year in which the dispute is finally resolved, determinations under subparagraphs (B) and (C) shall be made on the basis of the number of such children claimed by the State.

(E) The Secretary shall promulgate an interim allotment amount for purposes of this paragraph for each fiscal year for each State exercising its option to have its allotment determined under this paragraph, based on the most recent satisfactory data available, not later than six months after the beginning of such fiscal year. The amount of such allotment shall be adjusted, and the final allotment amount shall be promulgated, based on the most recent satisfactory data available, not later than nine months after the end of such fiscal year.

(6) Except in the case of a State which loses the option of having its allotment determined under paragraph (5) by reason of the provisions of paragraph (5)(C), and subject to the provisions of such paragraph (5)(C), the amount of any allotment as determined in accordance with subparagraph (A), (B), or (C) of paragraph (3) for any fiscal year for any State shall be determined in accordance with the provisions of such subparagraph, without regard to the amount of such State's allotment for any prior fiscal year as determined in accordance with another such subparagraph.

(c)(1) Except as provided in paragraphs (3) and (4), for any of the fiscal years 1981 through 1984 during which the limitation under subsection (b)(1) is in effect, sums available to a State from its allotment under subsection (b) for carrying out this part, which the State does not claim as reimbursement for expenditures in such year pursuant to subsection (a) of this section, may be claimed by the State as reimbursement for expenditures in such year pursuant to part B of this title, in addition to sums available pursuant to section 420 for carrying out part B.

(2) Except as provided in paragraphs (3) and (4), for any of the fiscal years 1981 through 1984 during which the limitation under subsection (b)(1) is not in effect, a State may claim as reimbursement for expenditures for such year pursuant to part B of this title, in addition

to amounts claimed under section 420, an amount equal to the amount by which the State's allotment amount for such fiscal year (as determined under subsection (b)(3)) exceeds the amount claimed by such State for such fiscal year as reimbursement for expenses relating to foster care under subsection (a); except that the total amount claimed by such State for such fiscal year under this paragraph, when added to the amount that such State receives for such fiscal year under section 420, may not exceed the amount that would have been payable to such State under section 420 for each fiscal year if the relevant amount described in subsection (b)(2)(A) had been appropriated for such fiscal year.

(3) The provisions of paragraphs (1) and (2) shall not apply for any fiscal year with respect to any State which, with respect to such fiscal year, exercised its option to have its allotment amount determined under subsection (b)(5).

(4)(A) No State may claim an amount under the provisions of this subsection as reimbursed for expenditures for any fiscal year pursuant to part B of this title to the extent that such amount, plus the amount claimed by such State for such fiscal year under section 420, exceeds the amount which would be allotted to such State under part B if the amount appropriated under section 420 were $141,000,000, unless such State has met the requirements set forth in section 427(a).

(B) If, for each of any two consecutive fiscal years, there is appropriated under section 420 a sum equal to $266,000,000, no State may claim any amount under the provisions of this subsection as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427(b).

(C) If, for each of any two fiscal years during which the limitation under subsection (b)(1) is not in effect, the total amount claimed by a State as reimbursement for expenditures pursuant to part B under this subsection and under section 420 equals the amount which would be allotted to such State for such fiscal year under part B if the amount appropriated under section 420 were $266,000,000, such State may not claim any amount under the provisions of paragraph (2) as reimbursement for expenditures for any succeeding fiscal year pursuant to part B of this title unless such State has met the requirements set forth in section 427(b).

(d)(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to which a State will be entitled under subsections (a), (b), and (c) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in

such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of children in the State receiving assistance under this part, and (c) such other investigation as the secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to foster care and adoption assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.[1]

Definitions

Sec. 475. As used in this part or part B of this title:

(1) The term "case plan" means a written document which includes at least the following: A description of the type of home or institution in which a child is to be placed, including a discussion of the appropriateness of the placement and how the agency which is responsible for the child plans to carry out the voluntary

[1] Subsec. (d) was added by sec. 3 of P.L. 96–611. The term "secretary" at the end of paragraph (1) is a technical error in the law. It should be capitalized.

(8) effective July 1, 1974, provides a program (carried out directly or through grants or contracts) of projects described in section 508 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily helping to reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with child bearing and of satisfactorily helping to reduce infant and maternal mortality;

(9) effective July 1, 1974, provides a program (carried out directly or through grants or contracts) of projects described in section 509 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the health of children and youth of school or preschool age;

(10) effective July 1, 1974, provides a program (carried out directly or through grants or contracts) of projects described in section 510 which offers reasonable assurance, particularly in areas with concentrations of low-income families, of satisfactorily promoting the dental health of children and youth of school or preschool age;

(11) provides for carrying out the purposes specified in section 501;

(12) provides for the development of demonstration services (with special attention to dental care for children and family planning services for mothers) in needy areas and among groups in special need;

(13) provides that, where payment is authorized under the plan for services which an optometrist is licensed to perform, the individual for whom such payment is authorized may, to the extent practicable, obtain such services from an optometrist licensed to perform such services except where such services are rendered in a clinic, or another appropriate institution, which does not have an arrangement with optometrists so licensed;

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan;

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services fur-

nished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title; and

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).[1]

(b) The Secretary shall approve any plan which meets the requirements of subsection (a).

Payments

Sec. 506. (a) From the sums appropriated therefor and the allotments available under section 503(1) or 504(1), as the case may be, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing July 1, 1968, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan with respect to maternal and child health services and services for crippled children, respectively.

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from

[1] Par. (16) was added by sec. 914(c) of P.L. 96-499 effective for services provided on and after Feb. 1, 1981.

which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

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Employment Security Administration Account

Establishment of Account

Section 901. (a) There is hereby established in the Unemployment Trust Fund an employment security administration account.

Appropriations to Account

(b)(1) There is hereby appropriated to the Unemployment Trust Fund for credit to the employment security administration account, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1961, and for each fiscal year thereafter, an amount equal to 100 per centum of the tax (including inter-

[1] This table of contents does not appear in the law.

est, penalties, and additions to the tax) received during the fiscal year under the Federal Unemployment Tax Act and covered into the Treasury.

(2) The amount appropriated by paragraph (1) shall be transferred at least monthly from the general fund of the Treasury to the Unemployment Trust Fund and credited to the employment security administration account. Each such transfer shall be based on estimates made by the Secretary of the Treasury of the amounts received in the Treasury. Proper adjustments shall be made in the amounts subsequently transferred, to the extent prior estimates (including estimates for the fiscal year ending June 30, 1960) were in excess of or were less than the amounts required to be transferred.

(3) The Secretary of the Treasury is directed to pay from time to time from the employment security administration account into the Treasury, as repayments to the account for refunding internal revenue collections, amounts equal to all refunds made after June 30, 1960, of amounts received as tax under the Federal Unemployment Tax Act (including interest on such refunds).

Administrative Expenditures

(c) (1) There are hereby authorized to be made available for expenditure out of the employment security administration account for the fiscal year ending June 30, 1971, and for each fiscal year thereafter—

(A) such amounts (not in excess of the applicable limit provided by paragraph (3) and, with respect to clause (ii), not in excess of the limit provided by paragraph (4)) as the Congress may deem appropriate for the purpose of—

(i) assisting the States in the administration of their unemployment compensation laws as provided in title III (including administration pursuant to agreements under any Federal unemployment compensation law),

(ii) the establishment and maintenance of systems of public employment offices in accordance with the Act of June 6, 1933, as amended (29 U.S.C., secs. 49–49n), and

(iii) carrying into effect section 2003 of title 38 of the United States Code;

(B) such amounts (not in excess of the limit provided by paragraph (4) with respect to clause (iii)) as the Congress may deem appropriate for the necessary expenses of the Department of Labor for the performance of its functions under—

(i) this title and titles III and XII of this Act,

(ii) the Federal Unemployment Tax Act,

(iii) the provisions of the Act of June 6, 1933, as amended,

(iv) chapter 41 (except section 2003) of title 38 of the United States Code, and

tending coverage to excluded groups with first attention to agricultural labor.

(b) To assist in the establishment and provide for the continuation of the comprehensive research program relating to the unemployment compensation system, there are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter, such sums, not to exceed $8,000,000, as may be necessary to carry out the purposes of this section. From the sums authorized to be appropriated by this subsection the Secretary may provide for the conduct of such research through grants or contracts.

Personnel Training

Sec. 907. (a) In order to assist in increasing the effectiveness and efficiency of administration of the unemployment compensation program by increasing the number of adequately trained personnel, the Secretary of Labor shall—

(1) provide directly, through State agencies, or through contracts with institutions of higher education or other qualified agencies, organizations, or institutions, programs and courses designed to train individuals to prepare them, or improve their qualifications, for service in the administration of the unemployment compensation program, including claims determinations and adjudication, with such stipends and allowances as may be permitted under regulations of the Secretary;

(2) develop training materials for and provide technical assistance to the State agencies in the operation of their training programs;

(3) under such regulations as he may prescribe, award fellowships and traineeships to persons in the Federal-State employment security agencies, in order to prepare them or improve their qualifications for service in the administration of the unemployment compensation program.

(b) The Secretary may, to the extent that he finds such action to be necessary, prescribe requirements to assure that any person receiving a fellowship, traineeship, stipend or allowance shall repay the costs thereof to the extent that such person fails to serve in the Federal-State employment security program for the period prescribed by the Secretary. The Secretary may relieve any individual of his obligation to so repay, in whole or in part, whenever and to the extent that such repayment would, in his judgment, be inequitable or would be contrary to the purposes of any of the programs established by this section.

(c) The Secretary, with the concurrence of the State, may detail Federal employees to State unemployment compensation administra-

tion and the Secretary may concur in the detailing of State employees to the United States Department of Labor for temporary periods for training or for purposes of unemployment compensation administration, and the provisions of section 507 of the Elementary and Secondary Education Act of 1965 (79 Stat. 27) or any more general program of interchange enacted by a law amending, supplementing or replacing section 507 shall apply to any such assignment.

(d) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $5,000,000, as may be necessary to carry out the purposes of this section.

Federal Advisory Council

Sec. 908. (a) The Secretary of Labor shall establish a Federal Advisory Council, of not to exceed 16 members including the chairman, for the purpose of reviewing the Federal-State program of unemployment compensation and making recommendations to him for improvement of the system.

(b) The Council shall be appointed by the Secretary without regard to the civil service laws and shall consist of men and women who shall be representatives of employers and employees in equal numbers, and the public.

(c) The Secretary may make available to the Council an Executive Secretary and secretarial, clerical, and other assistance, and such pertinent data prepared by the Department of Labor, as it may require to carry out its functions.

(d) Members of the Council shall, while serving on business of the Council, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by 5 U.S.C. 5703(b) for persons in government service employed intermittently.

(e) The Secretary shall encourage the organization of similar State advisory councils.

(f) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $100,000, as may be necessary to carry out the purposes of this section.

Federal Employees Compensation Account

Sec. 909. There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5, United States Code. For the purposes provided for in section 904(e), such account shall be maintained as a separate book account.[1]

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

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[1] This table of contents does not appear in the law.

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Part A—General Provisions

Definitions

Sec. 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa and the Trust Territory of the Pacific Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, title I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "States" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam.[2]

[1] This table of contents does not appear in the law.
[2] Paragraph (1) was amended by section 116(a) of P.L. 94-566 and by sec. 5(e)(2) of P.L. 95-142.

on, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.

(h) The provisions of this section shall not apply to Christian cience sanatoriums operated, or listed and certified, by the First hurch of Christ, Scientist, Boston, Massachusetts.

(i)(1) The Secretary shall establish a national advisory council, r designate an appropriate existing national advisory council, to dvise and assist him in the preparation of general regulations to carry ut the purposes of this section and on policy matters arising in the dministration of this section, including the coordination of activities nder this section with those under other parts of this Act or under ther Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultaon between and coordination of the work of the advisory council stablished or designated under paragraph (1) and the Federal Hosital Council, the National Advisory Health Council, the Health nsurance Benefits Advisory Council, and other appropriate national dvisory councils with respect to matters bearing on the purposes and dministration of this section and the coordination of activities under his section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise n the regular full-time employ of the United States, and who shall e appointed by the Secretary without regard to the civil service laws rom among leaders in the fields of the fundamental sciences, the medcal sciences, and the organization, delivery, and financing of health are, and persons who are State or local officials or are active in comnunity affairs or public or civic affairs or who are representative of ninority groups. Members of such advisory council, while attending neetings of the council or otherwise serving on business of the council, hall be entitled to receive compensation at rates fixed by the Secretary, ut not exceeding the maximum rate specified at the time of such servce for grade GS-18 in section 5332 of title 5, United States Code, ncluding traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of such title 5 for persons in the Government service employed intermittently.

Program for Determining Qualifications for Certain Health Care Personnel

Sec. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health

organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, 1981, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.[1]

(b) If any individual has been determined, under the program established pursuant to subsection (a), to be qualified to perform the duties and functions of any health care specialty, no person or provider utilizing the services of such individual to perform such duties and functions shall be denied payment, under title XVIII or under any State plan approved under title XIX, for any health care services provided by such person on the grounds that such individual is not qualified to perform such duties and functions.

Disclosure of Ownership and Related Information[2]

Sec. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, XIX, and XX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, XIX, and XX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

[1] Subsec. (a) was amended by sec. 911 of P.L. 96–499.
[2] Sec. 1124 was added by sec. 3(a)(1) of P.L. 95–142.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX;

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX; or

(D) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under title XX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or[1]

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

[1] Clause (ii) was amended by sec. 912(a) of P.L. 96–499.

Issuance of Subpenas by Comptroller General [1]

Sec. 1125. (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under this Act, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

(b) In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General shall be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title, relating to classification and General Schedule pay rates.

(c) No personal medical record in the possession of the General Accounting Office shall be subject to subpena or discovery proceedings in a civil action.

Disclosure by Institutions, Organizations, and Agencies of Owners and Certain Other Individuals Who Have Been Convicted of Certain Offenses [2]

Sec. 1126. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution,

[1] Section 1125 was added by sec. 6 of P.L. 95–142.
[2] Section 1126 was added by sec. 8(a) of P.L. 95–142.

months as would not have been paid with respect to such individual or his eligible spouse if the individual had received the benefits under title II at the times they were regularly due during such period rather than retroactively; and from the amount of such reduction the Secretary shall reimburse the State on behalf of which such supplementary payments were made for the amount (if any) by which such State's expenditures on account of such supplementary payments for the period involved exceeded the expenditures which the State would have made (for such period) if the individual had received the benefits under title II at the times they were regularly due during such period rather than retroactively. An amount equal to the portion of such reduction remaining after reimbursement of the State under the preceding sentence shall be covered into the general fund of the Treasury.[1]

Exclusion of Certain Individuals Convicted of Medicare- or Medicaid-Related Crimes [2]

Sec. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary—

(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX or title XX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX or title XX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification

[1] Sec. 1127 was added by sec. 501 of P.L. 96–265 effective July 1981.
[2] Sec. 1128 was added by sec. 913(a) of P.L. 96–499.

of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Coordinated Audits [1]

Sec. 1129. (a) If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in

[1] Sec. 1129 was added by sec. 914(a) of P.L. 96-499. See excerpt from sec. 914(d) of that act for required report on this amendment.

excess of the amount that would have been apportioned to the State under the title (for the expenses of the Sale incurred in the common audit) if it had participated in the common audit.

(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

(3) The Secretary shall report to Congress not later than December 31, 1982, with respect to demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than December 31, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.

Sec. 1130. [Repealed.]

Notification of Social Security Claimant With Respect to Deferred Vested Benefits

Sec. 1131. (a) Whenever—

(1) the Secretary makes a finding of fact and a decision as to—

(A) the entitlement of any individual to monthly benefits under section 202, 223, or 228,

(B) the entitlement of any individual to a lump-sum death payment payable under section 202(i) on account of the death of any person to whom such individual is related by blood, marriage, or adoption, or

(C) the entitlement under section 226 of any individual to hospital insurance benefits under part A of title XVIII, or

(2) the Secretary is requested to do so—

(A) by any individual with respect to whom the Secretary holds information obtained under section 6057 of the Internal Revenue Code of 1954, or

(B) in the case of the death of the individual referred to in subparagraph (A), by the individual who would be entitled to payment under section 204(d) of this Act,

he shall transmit to the individual referred to in paragraph (1) or the individual making the request under paragraph (2) any information, as reported by the employer, regarding any deferred vested benefit transmitted to the Secretary pursuant to such section 6057 with respect to the individual referred to in paragraph (1) or (2)(A) or the person on whose wages and self-employment income entitlement (or claim of entitlement) is based.

(b)(1) For purposes of section 201(g)(1), expenses incurred in the administration of subsection (a) shall be deemed to be expenses incurred for the administration of title II.

(2) There are hereby authorized to be appropriated to the Federal Old-Age and Survivors Insurance Trust Fund for each fiscal year (commencing with the fiscal year ending June 30, 1974) such sums as the Secretary deems necessary on account of additional administrative expenses resulting from the enactment of the provisions of subsection (a).

Period Within Which Certain Claims Must Be Filed

Sec. 1132. (a) Notwithstanding any other provision of this Act (but subject to subsection(b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

(1) in carrying out a State plan approved under title I, IV, V, X, XIV, XVI, XIX, or XX of this Act, or

(2) under any other provision of this Act which provides (on an entitlement basis) for Federal financial participation in expenditures made under State plans or programs,

shall be filed (in such form and manner as the Secretary shall by regulations prescribe) within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter; and payment shall not be made under this Act on account of any such expenditure if claim therefor is not made within such two-year period; except that this subsection shall not be applied so as to deny payment with respect to any expenditure involving court-ordered retroactive payments or audit exceptions, or adjustments to prior year costs.

(b) The Secretary shall waive the requirement imposed under subsection (a) with respect to the filing of any claim if he determines (in accordance with regulations) that there was good cause for the failure by the State to file such claim within the period prescribed under subsection (a). Any such waiver shall be only for such additional period of time as may be necessary to provide the State with a reasonable

opportunity to file such claim. A failure to file a claim within such time period which is attributable to neglect or administrative inadequacies shall be deemed not to be for good cause.[1]

Applicants or Recipients Under Public Assistance Programs Not To Be Required To Make Election Respecting Certain Veterans' Benefits

Sec. 1133. (a) Notwithstanding any other provision of law (but subject to subsection (b)), no individual who is an applicant for or recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, or of benefits under the Supplemental Security Income program established by title XVI shall—

(1) be required, as a condition of eligibility for (or of continuing to receive) such aid, assistance, or benefits, to make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 with respect to pension paid by the Veterans' Administration, or

(2) by reason of failure or refusal to make such an election, be denied (or suffer a reduction in the amount of) such aid, assistance, or benefits.

(b) The provisions of subsection (a) shall be applicable only with respect to an individual, who is an applicant for or recipient of aid, assistance, or benefits described in subsection (a), during a period with respect to which there is in effect—

(1) in case such individual is an applicant for or recipient of aid or assistance under a State plan referred to in subsection (a), in the State having such plan, or

(2) in case such individual is an applicant for or recipient of benefits under the Supplemental Security Income program established by title XVI, in the State in which the individual applies for or receives such benefits,

a State plan for medical assistance, approved under title XIX, under which medical assistance is available to such individual only for periods for which such individual is a recipient of aid, assistance, or benefits described in subsection (a).[2]

Nonprofit Hospital Philanthropy[3]

Sec. 1134. For purposes of determining, under titles V, XVIII, and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals:

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[1] Sec. 1132 was added by sec. 306 of P.L. 96–272.

[2] Sec. 1133 was added by sec. 310 of P.L. 96–272. See excerpt from P.L. 96–272 (sec. 310).

[3] Sec. 1134 was added by sec. 901(a) of P.L. 96–499.

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital which was made by a government entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.

Part B—Professional Standards Review

Declaration of Purpose

Sec. 1151. In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this Act and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under the Social Security Act will conform to appropriate professional standards for the provision of health care and that payment for such services will be made—

(1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and

(2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

Designation of Professional Standards Review Organizations

Sec. 1152. (a) The Secretary shall (1) not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and (2) at the earliest practicable date after designation of an area enter into an agreement with a qualified organization whereby such an organization shall be conditionally designated as the Professional Standards Review Organization for such area. If, on the basis of its performance during such period of conditional designation, the Secretary determines that such organization is capable of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization under this part, he shall enter into an agreement with such organization designating it as the Professional Standards Review Organization for such area.

(b) For purposes of subsection (a), the term "qualified organization" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not (except as otherwise provided under section 1155(c)) restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(1),[1]

[1] Subpar. (A) was amended by sec. 5(o)(1) of P.L. 95–142 and by sec. 921 of P.L. 96–499.

(B) such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable; and

(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan which shall be de-

veloped and submitted by the association, agency, or organization in accordance with subsection (h) (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and activities of a Professional Standards Review Organization required by or pursuant to this part.[1]

(c) (1) The Secretary shall not enter into any agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A) prior to January 1, 1978, nor after such date, unless, in such area, there is no organization referred to in subsection (b) (1) (A) which meets the conditions specified in subsection (b) (2).[2]

(2) Whenever the Secretary shall have entered into an agreement under this part under which there is designated as the Professional Standards Review Organization for any area any organization other than an organization referred to in subsection (b) (1) (A), he shall not renew such agreements with such organization if he determines that—

(A) there is in such area an organization referred to in subsection (b) (1) (A) which (i) has not been previously designated as a Professional Standards Review Organization, and (ii) is willing to enter into an agreement under this part under which such organization would be designated as the Professional Standards Review Organization for such area;

(B) such organization meets the conditions specified in subsection (b) (2); and

(C) the designation of such organization as the Professional Standards Review Organization for such area is anticipated to result in substantial improvement in the performance in such area of the duties and functions required of such organizations under this part.

(d) Any such agreement under this part with an organization (other than an agreement established pursuant to section 1154) shall be for a term of 12 months; except that, prior to the expiration of such term such agreement may be terminated—

(1) by the organization at such time and upon such notice to the Secretary as may be prescribed in regulations (except that notice of more than 3 months may not be required); or

(2) by the Secretary at such time and upon such reasonable notice to the organization as may be prescribed in regulations,

[1] Paragraph (2) was amended by sec. 5(d)(2)(A) of P.L. 95-142.
[2] Date in subsection (c)(1) changed from "January 1, 1976" to "January 1, 1978" by section 108(a) of Public Law 94-182 subject to limitations specified in section 108(b) of the same act, which is reprinted in this document on page 770.

respect to matters involving the provision of health care services in such area for which payment (in whole or in part) may be made, under this Act, any review with respect to such services which has not been designated by the Secretary as the full responsibility of such organization, shall be reviewed in the manner otherwise provided for under law.

Trial Period for Professional Standards Review Organizations

Sec. 1154. (a) The Secretary shall initially designate an organization as a Professional Standards Review Organization for any area on a conditional basis with a view to determining the capacity of such organization to perform the duties and functions imposed under this part on Professional Standards Review Organizations. Such designation may not be made prior to receipt from such organization and approval by the Secretary of a formal plan for the orderly assumption and implementation of the responsibilities of the Professional Standards Review Organization under this part.

(b) During any such trial period (which may not exceed 48 months except as provided in subsection (c)), the Secretary may require a Professional Standards Review Organization to perform, in addition to review of health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals and to review of alcohol detoxification facility services, only such of the duties and functions as he requires the organization to perform under subsection (f) (2) or subsection (f) (4) and which the organization is capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the activities and functions required of that Professional Standards Review Organization under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require. Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.[1]

(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.[2]

[1] Subsec. (b) was amended by sec. 5(b)((1) of P.L. 95-142 and by sec. 924(a)(1) of P.L. 96-499.
[2] Subsec. (c) was added (and the former subsec. (c) was redesignated as subsec. (d)) by sec. 5(b)(2) of P.L. 95-142 and was amended by sec. 924(a)(2) of P.L. 96-499.

(d) Any agreement under which any organization is conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon 90 days notice to the Secretary or by the Secretary upon 90 days notice to such organization.[1]

(e) In determining whether an organization designated on a conditional basis as the Professional Standards Review Organization for any area is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, the Secretary shall follow the procedures specified in section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).[2]

(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the "program") for the evaluation of the cost-effectiveness of review of particular health care services by Professional Standards Review Organizations.

(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall such particular health care services which Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

(5) For purposes of this subsection, the term "particular health care services" does not include health care service (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals or alcohol detoxification facility services.[3]

Duties and Functions of Professional Standards Review Organizations

Sec. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for

[1] Former subsection (c) was redesignated as subsection (d) by sec. 5(b)(2) of P.L. 95–142.

any area to assume, to the extent and at the time specified by the Secretary under section 1154(f), responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services (except as provided in paragraph (7)) in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.[1]

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital, or other health care facility (including admissions occurring on weekends), and

(B) any routine diagnostic services furnished in connection with such an admission,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1). Each such Organization may be directed by the Secretary to exercise such authority where the Secretary finds (consistent with section 1154(f)) that such determinations can be made on a timely basis by the Organization and appropriate procedures will be applied to assure prompt notification of such determinations to providers, physicians, practitioners, and persons on whose behalf payment may be made under this Act for services and items.[2]

[1] Par. (1) was amended by sec. 5(d)(3)(B)(i) and sec. 5(o)(2) of P.L. 95–142 and by sec. 924(b)(1) of P.L. 96–499.

[2] Par. (2) was amended by sec. 926 of P.L. 96–499.

(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order most effectively to carry out the purposes of this part, exercise the authority conferred upon it under paragraph (2).

(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization.[1]

(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly responsible for providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.[2]

(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only, consistent with section 1154 (f), if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for the State is not performing effective review of the quality and necessity of health care services provided in

[1] Par. (5) was amended by sec. 5(p) of P.L. 95–142.

[2] Par. (6) was amended by sec. 5(c)(1) (A) and (B) of P.L. 95–142.

such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent (consistent with section 1154(f)) that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.[1]

(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.[2]

(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—

(1) make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization;

(2) undertake such professional inquiry either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review under subsection (a)(1);

(3) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a)(1); and

(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

(c) No Professional Standards Review Organization shall utilize the services of any individual who is not a duly licensed doctor of medicine or osteopathy to make final determinations in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine or osteopathy, or any act performed by any duly licensed doctor of medicine or osteopathy in the exercise of his profession.

[1] Par. (7) was added by sec. 5(d)(3)(ii) of P.L. 95-142 and was amended by sec. 924(b) of P.L. 96-499.

[2] Par. (8) was added by sec. 927(a) of P.L. 96-499 effective June 4, 1981.

(d) In order to familiarize physicians with the review functions and activities of Professional Standards Review Organizations and to promote acceptance of such functions and activities by physicians, patients, and other persons, each Professional Standards Review Organization, in carrying out its review responsibilities, shall (to the maximum extent consistent with the effective and timely performance of its duties and functions)—

(1) encourage all physicians practicing their profession in the area served by such Organization to participate as reviewers in the review activities of such Organizations;

(2) provide rotating physician membership of review committees on an extensive and continuing basis;

(3) assure that membership on review committees have the broadest representation feasible in terms of the various types of practice in which physicians engage in the area served by such Organization; and

(4) utilize, whenever appropriate, medical periodicals and similar publications to publicize the functions and activities of Professional Standards Review Organizations.

(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital (including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(c), which is also a part of such hospital) or other operating health care facility or organization (other than such a skilled nursing facility or intermediate care facility which is not a part of a hospital) located in the areas served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity effectively, efficiently, and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary disapproves, for good cause, such acceptance.[1]

(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

(f)(1) An agreement entered into under this part between the Secretary and any organization under which such organization is designated as the Professional Standards Review Organization for any area shall provide that such organization will—

[1] Par. (1) was amended by sec. 5(d)(3)(A) of P.L. 95-142 and by sec. 925 of P.L.

(A) perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part; and

(B) collect such data relevant to its functions and such information and keep and maintain such records in such form as the Secretary may require to carry out the purposes of this part and to permit access to and use of any such records as the Secretary may require for such purposes.

(2) Any such agreement with an organization under this part shall provide that the Secretary make payments to such organization equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

(3) Any such agreement with an organization under this part may be in the form of a grant or an assistance agreement.[1]

(g) [Repealed.][2]

(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.[3]

(i) Any Professional Standards Review Organization which has assumed responsibility under this section for review of inpatient hospital services in an area shall also assume responsibility in such area for review of detoxification facility services.[4]

Norms of Health Care Services for Various Illnesses or Health Conditions

Sec. 1156. (a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (including typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review. The National Professional Standards Review Council and the Secretary shall provide such technical assistance to the organization as will be helpful in utilizing and applying such norms of care, diagnosis, and treatment. Where the actual norms of care, diagnosis, and treatment in a Professional Standards Review Organization area are significantly different from professionally developed regional norms of care, diagnosis, and treatment approved for comparable conditions, the Professional Standards Review Organization concerned shall be so informed, and in the event that appropriate consultation and discussion indicate reasonable basis for usage of other norms in the area concerned, the Professional Standards Review Organization may apply such norms in such area as are approved by the National Professional Standards Review Council.

(b) Such norms with respect to treatment for particular illnesses or health conditions shall include (in accordance with regulations of the Secretary)—

(1) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;

(2) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

(c)(1) The National Professional Standards Review Council shall provide for the preparation and distribution, to each Professional Standards Review Organization and to each other agency or person performing review functions with respect to the provision of health care services under this Act, of appropriate materials indicating the regional norms to be utilized pursuant to this part. Such data concerning norms shall be reviewed and revised from time to time. The approval of the National Professional Standards Review Council of norms of care, diagnosis, and treatment shall be based on its analysis of appropriate and adequate data.

(2) Each review organization, agency, or person referred to in paragraph (1) shall utilize the norms developed under this section as a principal point of evaluation and review for determining, with respect to any health care services which have been or are proposed to be provided, whether such care and services are consistent with the criteria specified in section 1155(a)(1).

[1] Par. (3) was added by sec. 5(c)(1)(C) of P.L. 95-142.
[2] Subsec. (g) was repealed by sec. 924(c) of P.L. 96-499.
[3] Subsec. (h) was added by sec. 924(d) of P.L. 96-499.
[4] Subsec. (i) was added by sec. 931(g) of P.L. 96-499.

(d)(1) Each Professional Standards Review Organization shall—

(A) in accordance with regulations of the Secretary, specify the appropriate points in time after the admission of a patient for inpatient care in a health care institution, at which the physician attending such patient shall execute a certification stating that further inpatient care in such institution will be medically necessary effectively to meet the health care needs of such patient; and

(B) require that there be included in any such certification with respect to any patient such information as may be necessary to enable such organization properly to evaluate the medical necessity of the further institutional health care recommended by the physician executing such certification.

(2) The points in time at which any such certification will be required (usually, not later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnosis) shall be consistent with and based on professionally developed norms of care and treatment and data developed with respect to length of stay in health care institutions of patients having various illnesses, injuries, or health conditions, and requiring various types of health care services or procedures.

Submission of Reports by Professional Standards Review Organizations

Sec. 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by section 1160, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such organization is located together with the recommendations of such Organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional comments or recommendations thereon as it deems appropriate.[1]

Requirement of Review Approval as Condition of Payment of Claims

Sec. 1158. (a) Except as provided for in subsections (d) and (e) of this section and in sections 1159. 1861(v)(1)(G), and 1902 (h), no Federal funds appropriated under any title of this Act (other than

[1] Sec. 1157 was amended by sec. 13(b)(4) of P.L. 95-142.

title V), for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.[1]

(b) Whenever any Professional Standards Review Organization, in the discharge of its duties and functions as specified by or pursuant to this part, disapproves of any health care services or items furnished or to be furnished by any practitioner or provider, such organization shall, after notifying the practitioner, provider, or other organization or agency of its disapproval in accordance with subsection (a), promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services or items.

(c) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155 (a) in connection with such reviews shall constitute the conclusive determination on those issues (subject to sections 1159, 1171(a)(1), and 1171(d)(3)) for purposes of payment under this Act, and no reviews with respect to those determinations shall be conducted, for purposes of payment, by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State agencies administering or supervising the administration of State plans approved under title XIX.[2]

(d) In any case in which a Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital

[1] Subsec. (a) was amended by sec. 22(a)(1) of P.L. 95-142 and by sec. 931(n)(1) of P.L. 96-499.

[2] Subsec. (c) was added by sec. 5(d)(1) of P.L. 95-142.

services or posthospital extended care services, payment may be made for such services furnished before the second day after the day on which the provider received notice of such disapproval, or, if such organization determines that more time is required in order to arrange postdischarge care, payment may be made for such services furnished before the fourth day after the day on which the provider received notice of such disapproval. In the case of disapproval of inpatient hospital services where payment for inpatient services is continued under section 1861(v)(1)(G) or section 1902(h), the previous sentence shall not apply with respect to such disapproval.[1]

(e) Subsection (a) of this section shall not apply to a determination by a Professional Standards Review Organization under section 1155(a)(1)(C) that detoxification services provided or proposed to be provided in a hospital on an inpatient basis could be more economically provided in a detoxification facility.[2]

Hearings and Review by Secretary

Sec. 1159. (a) Any beneficiary or recipient who is entitled to benefits under this Act (other than title V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1155(a) shall, after being notified of such determination, be entitled to a reconsideration thereof by the Professional Standards Review Organization and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is $100 or more, such determination shall be reviewed by professional members of such Council and, if the Council so determines, revised.

(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is $100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). The Secretary will render a decision only after appropriate professional consultation on the matter.

[1] Subsec. (d) was added by sec. 22(a)(2) of P.L. 95-142. The last sentence of subsec. (d) was added by sec. 902(a)(3) of P.L. 96-499 effective upon the promulgation (not later than June 1, 1981) of final regulations.

[2] Subsec. (e) was added by sec. 931(h)(2) of P.L. 96-499.

(c) Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this Act with respect to the same issue.

Obligations of Health Care Practitioners and Providers of Health Care Services; Sanctions and Penalties; Hearings and Review

Sec. 1160. (a)(1) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this Act, to assure that services or items ordered or provided by

(1) one representative from and designated by each Professional Standards Review Organization in the State;

(2) four physicians, two of whom may be designated by the State medical society and two of whom may be designated by the State hospital association of such State to serve as members on such Council; and

(3) four persons knowledgeable in health care from such State whom the Secretary shall have selected as representatives of the public in such State (at least two of whom shall have been recommended for membership on the Council by the Governor of such State).

(c) It shall be the duty and function of the Statewide Professional Standards Review Council for any State, in accordance with regulations of the Secretary, (1) to coordinate the activities of, and disseminate information and data among the various Professional Standards Review Organizations within such State including assisting the Secretary in development of uniform data gathering procedures and operating procedures applicable to the several areas in a State (including, where appropriate, common data processing operations serving several or all areas) to assure efficient operation and objective evaluation of comparative performance of the several areas and, (2) to assist the Secretary in evaluating the performance of each Professional Standards Review Organization, and (3) where the Secretary finds it necessary to replace a Professional Standards Review Organization, to assist him in developing and arranging for a qualified replacement Professional Standards Review Organization.

(d) The Secretary is authorized to enter into an agreement with any such Council under which the Secretary shall make payments to such Council equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such Council in carrying out the duties and functions provided in this section.

(e)(1) The Statewide Professional Standards Review Council for any State shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives (including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine) of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council.

(3) The expenses reasonably and necessarily incurred, as determined by the Secretary, by such group in carrying out its duties and functions under this subsection shall be considered to be expenses necessarily incurred by the Statewide Professional Standards Review Council served by such group.[1]

National Professional Standards Review Council

Sec. 1163. (a) (1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1)), not otherwise in the employ of the United States, appointed by the Secretary without regard to the provision of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than five members expire in any year. Members of the Council shall be eligible for reappointment.[2]

(3) The Secretary shall from time to time designate one of the physician members of the Council to serve as Chairman thereof.[2]

(b) Physician members of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.[3]

(c) The Council is authorized to utilize, and the Secretary shall make available, or arrange for, such technical and professional consultative assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical and other assistance and such pertinent data prepared by, for, or otherwise available to, the Department of Health, Education, and Welfare as the Council may require to carry out its functions.

[1] Subsec. (e) was amended, effective June 4, 1981, by secs. 922 and 927(b) of P.L. 96–499.

[2] Subsec. (a) was amended, effective June 4, 1981, by sec. 923(a)–(c) of P.L. 96–499.

[3] Subsec. (b) was amended, effective June 4, 1981, by sec. 923(d) of P.L. 96–499.

(d) Members of the Council, while serving on business of the Council, shall be entitled to receive compensation at a rate fixed by the Secretary (but not in excess of the daily rate paid under GS–18 of the General Schedule under section 5332 of title 5, United States

Code), including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(e) It shall be the duty of the Council to—

(1) advise the Secretary in the administration of this part;

(2) provide for the development and distribution, among Statewide Professional Standards Review Councils and Professional Standards Review Organizations of information and data which will assist such review councils and organizations in carrying out their duties and functions;

(3) review the operations of Statewide Professional Standards Review Councils and Professional Standards Review Organizations with a view to determining the effectiveness and comparative performance of such review councils and organizations in carrying out the purposes of this part; and

(4) make or arrange for the making of studies and investigations with a view to developing and recommending to the Secretary and to the Congress measures designed more effectively to accomplish the purposes and objectives of this part.

(f) [Repealed] [1]

Application of This Part to Certain State Programs Receiving Federal Financial Assistance

Sec. 1164. (a) In addition to the requirements imposed by law as a condition of approval of a State plan approved under any title of this Act under which health care services are paid for in whole or part, with Federal funds, there is hereby imposed the requirement that provisions of this part shall apply to the operation of such plan or program.

(b) The requirement imposed by subsection (a) with respect to such State plans approved under this Act shall apply—

(1) in the case of any such plan where legislative action by the State legislature is not necessary to meet such requirement, on and after January 1, 1974; and

(2) in the case of any such plan where legislative action by the State legislature is necessary to meet such requirement, whichever of the following is earlier—

(A) on and after July 1, 1974, or

(B) on and after the first day of the calendar month which first commences more than ninety days after the close of the first regular session of the legislature of such State which begins after December 31, 1973.

[1] Subsection (f) was repealed by sec. 5(g) of P.L. 95–142.

Secretary shall, within thirty days from the date of receipt of the documentation, make a determination as to the reasonableness of the allegation by the State agency. If the Secretary determines that the review determinations of such organization have caused an unreasonable and detrimental impact on total State expenditures under title XIX and on the appropriateness of care received by individuals under the State's plan approved under such title, unless the Secretary determines that the organization has taken appropriate corrective action, he shall immediately suspend such organization's authority in whole or in part under section 1158(c) to make conclusive determinations for purposes of payment under title XIX (and he may suspend such authority for purposes of payment under title XVIII) until he (i) reevaluates such organization's performance of the responsibilities involved and determines that such performance does not have such unreasonable and detrimental impact, or (ii) determines that the organization has taken appropriate corrective action. Any determination made by the Secretary under this subparagraph shall be final and shall not be subject to judicial review.

(B) The Secretary shall notify the State agency submitting such documentation, and the organization involved, in writing, of his determination, any subsequent actions taken, and the basis thereof, and shall notify the appropriate committees of the United States House of Representatives and the Senate of any such documentation submitted and the actions taken.

(e)(1) The Secretary shall in a timely manner establish procedures and mechanisms to govern his relationships with State agencies under this part (specifically including his relationships with such agencies in connection with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation by the Secretary with State agency representatives and representatives of Professional Standards Review Organizations regarding relationships between such agencies and such organizations (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern, and such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a Professional Standards Review Organization located within its State.

(2) Each Professional Standards Review Organization shall provide to the State agency for the State in which it is located, upon request, data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and such other data or information as the Secretary authorizes to be disclosed.

Annual Reports [1]

Sec. 1172. The Secretary shall submit to the Congress not later than April 1, 1978, and not later than April 1 of each year thereafter, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

(1) the number, status (conditional or otherwise), and service areas of, and review methodologies employed by, all Professional Standards Review Organizations participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by Professional Standards Review Organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) The imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

(4) the total costs incurred under titles V, XI, XVIII, and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

(5) changes in utilization rates and patterns, and changes in medical procedures and practices, attributable to the activities of Professional Standards Review Organizations;

(6) the results of program evaluation activities, including the operation of data collection systems and the status of Professional Standards Review Organization data policy and implementation;

(7) the extent to which Professional Standards Review Organizations are performing reviews of services for other governmental or private health insurance programs; and

(8) recommendations for legislative changes.

Medical Officers in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands To Be Included in the Professional Standards Review Program [2]

Sec. 1173. For purposes of applying this part (except section 1155(c)) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.[3]

[1] Sec. 1172 was added by sec. 5(k) of P.L. 95–142.
[2] Sec. 1173 was added by sec. 5(l)(1) of P.L. 95–142.
[3] Sec. 1173 was amended, effective June 4, 1981, by sec. 923(e) of P.L. 96–499.

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

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Purpose; Appropriations

Section 1601. For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this title.

[1] This table of contents does not appear in the law.

Basic Eligibility for Benefits

Section 1602. Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be paid benefits by the Secretary of Health, Education, and Welfare.

Part A—Determination of Benefits

Eligibility for and Amount of Benefits

Definition of Eligible Individual

Sec. 1611. (a)(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1612(b), is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1617)[1] for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1613(a), are not more than (i) in case such individual has a spouse with whom he is living, $2,250, or (ii) in case such individual has no spouse with whom he is living, $1,500,

shall be an eligible individual for purposes of this title.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1612(b), is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1617)[1] for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1613(a), are not more than $2,250,

shall be an eligible individual for purposes of this title.

Amounts of Benefits

(b)(1) The benefit under this title for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1617)[1] for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1612(b), of such individual.

(2) The benefit under this title for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1617)[1] for the calendar year 1974 and

[1] See Appendix E.

fits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

Disposal of Resources for Less Than Fair Market Value

(c)(1) In determining the resources of an individual (and his eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a)) any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.

(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

(3) For purposes of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any.[1]

Meaning of Terms

Aged, Blind, or Disabled Individual

Sec. 1614. (a)(1) For purposes of this title, the term "aged, blind, or disabled individual" means an individual who—

[1] Subsec. (c) was added by sec. 5(a) of P.L. 96-611.

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[1] This table of contents does not appear in the law.

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Prohibition Against Any Federal Interference

Section 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Free Choice by Patient Guaranteed

Sec. 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

Option to Individuals To Obtain Other Health Insurance Protection

Sec. 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

Part A—Hospital Insurance Benefits for the Aged and Disabled

Description of Program

Sec. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, related post-hospital, and home health services in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.[1]

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital

[1] Sec. 1811 was amended by sec. 4(a) of P.L. 95–292, sec. 103 of P.L. 96–265, by sec. 2(b) of P.L. 96–473, and, with respect to services furnished on or after July 1, 1981, by sec. 930(a) of P.L. 96–499.

services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness;

(3) home health services; and [1]

(4) alcohol detoxification facility services.[2]

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

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

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

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

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

(d) [Repealed.] [3]

[1] Par. (3) was amended, with respect to services furnished on or after July 1, 1981, by sec. 930(b) of P.L. 96-499.

[2] Par. (4) was added by sec. 931(a) of P.L. 96-499.

[3] Subsec. (d) was repealed, with respect to services furnished on or after July 1, 1981, by sec. 930(c) of P.L. 96-499.

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.[1]

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

Deductibles and Coinsurance

Sec. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by

[1] Subsec. (e) was amended, with respect to services furnished on or after July 1, 1981, by sec. 930(d) of P.L. 96-499.

a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

(b)(1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) shall be $40 in the case of any spell of illness beginning before 1969.

(2) The Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) in the case of any spell of illness beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to $40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1866, to individuals who are entitled to hospital insurance benefits under section 226, plus the amount which would have been so paid but for subsection (a)(1) of this section.

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

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

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

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a

physician; and such services are or were furnished while the individual was under the care of a physician; [1]

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, require hospitalization in connection with the provision of such services; or [2]

(F) in the case of alcohol detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification); [3]

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

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

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

[1] Subpar. (D) was amended, with respect to services furnished on or after July 1, 1981, by sec. 930(f) of P.L. 96-499.

[2] Subpar. (E) was amended, with respect to services furnished on or after July 1, 1981, by sec. 936(b) of P.L. 96-499.

[3] Subpar. (F) was added by sec. 931(b) of P.L. 96-499.

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.[1]

Amount Paid to Providers

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or

[1] Subsec. (b) was amended by sec. 4(f) of P.L. 95–292 and by sec. 903(a) of P.L. 96–499.

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

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

(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the Secretary determines that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred.[1]

No Payments to Federal Providers of Services

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection (h)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.[2]

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[1] The last sentence of subsec. (a) was added, with respect to services furnished on or after July 1, 1981, by sec. 930(e) of P.L. 96–499.

[2] Subsec. (c) was amended by sec. 101(a) of P.L. 94–437, sec. 231(a) of P.L. 95–142, and sec. 941(b) of P.L. 96–499.

Payments for Emergency Hospital Services

(d) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for the services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or legal holiday) after the day on which such admission occurred.

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

(f) (1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—

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

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

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

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

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

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

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

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the

hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1813, be equal to the amount which would be payable under subsection (d)(3).

Payment for Services of a Physician Rendered in a Teaching Hospital

(g) For purposes of services for which the reasonable cost thereof is determined under section 1861(v)(1)(D), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(1) such hospital has an agreement with the Secretary under section 1866, and

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

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

(h)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).[1]

Payment to Providers of Services

Sec. 1815. (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or

[1] Subsec. (h), formerly subsec. (j) was added by sec. 23(b) of P.L. 95–142 and was redesignated by sec. 941(a) of P.L. 96–499, which also struck out former subsecs. (h) and (i) relating to posthospital extended care and home health services.

(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.[1]

(c) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement.

(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may (subject to the provisions of paragraph (4)) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.[2]

[1] Subsec. (b) was amended by sec. 14(a)(2) of P.L. 95–142 effective as specified in subsecs. (c) and (d) of sec. 14 which are printed in this document on p. 798.

[2] Par. (2) was amended by sec. 930(o)(1) of P.L. 96–499.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861(o)) in the region, except that in assigning such agencies to such designated regional agencies or organizations the Secretary shall assign a home health agency which is a subdivision of a hospital (and such agency and hospital are affiliated or under common control) only if, after applying such criteria relating to administrative efficiency and effectiveness as he shall promulgate, he determines that such assignment would result in the more effective and efficient administration of this title.[1]

(f) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and

[1] Subsec. (e) was added (and the former subsec. (e) was redesignated (g)) by sec. 14(a) (4) and (5) of P.L. 95–142. Par. (4) was added by sec. 930(o)(2) of P.L. 96–499.

(2) performance of such functions with respect to specific providers of services, and the Secretary shall establish, by regulation, standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not to be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.[1]

(g) An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after applying the standards, criteria, and procedures developed under subsection (f) and after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.[2]

(h) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.[3]

(i)(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

[1] Subsec. (f) was added (and former subsec. (f) was redesignated (h)) by sec. 14(a) (4) and (5) of P.L. 95–142 effective as specified in sec. 14(b) which is printed in this document on p. 798.

[2] Subsec. (g) was formerly subsec. (e) and was redesignated by sec. 14(a)(4) of P.L. 95–142. The subsection was amended by sec. 14(a)(3) of P.L. 95–142 effective as specified in sec. 14(c) which is printed in this document on p. 798.

[3] Subsecs. (h) and (i) were formerly (f) and (g) respectively and were redesignated by sec. 14(a)(4) of P.L. 95–142.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).[1]

Federal Hospital Insurance Trust Fund

Sec. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such

[1] Subsecs. (h) and (i) were formerly (f) and (g) respectively and were redesignated by sec. 14(a)(4) of P.L. 95–142.

hospital insurance program shall take effect at the close of the month following the month in which such notice is filed;

(5) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement; and

(6) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act.

(d)(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

(2) The Secretary shall, during the last calendar quarter of each year, beginning in 1973, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductible for such next year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or if midway between multiples of $1 to the next higher multiple of $1.

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

Establishment of Supplementary Medical Insurance Program for the Aged and the Disabled

Sec. 1831. There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the pro-

visions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

Scope of Benefits

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services;

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) where the conditions specified in paragraph (7) of such section are met, and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies;

(D) rural health clinic services;

(E) comprehensive outpatient rehabilitation facility services; and

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

(i) pursuant to section 1833(i)(1)(A) and performed in an ambulatory surgical center (which meets health, safety, and other standards specified by the Secretary in regulations) if the center has an agreement in effect with the Secretary by which the center agrees to accept the amount determined under section 1833(i)(2)(A) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all such services furnished by the center to individuals enrolled under this part, or

(ii) pursuant to section 1833(i)(1)(B) and performed by a physician, described in section 1861(r)(1), in his office, if the Secretary has determined that—

(I) a Professional Standards Review Organization (designated, conditionally or otherwise, under part B of title XI of this Act) is willing, able, and has agreed to carry out a review (on a sample or other reasonable basis) of the physician's performing such procedures in the physician's office,

(II) the particular physician involved has agreed to make available to such Organization such records as the Secretary determines to be necessary to carry out the review, and

(III) the physician is authorized to perform the procedure in a hospital located in the area in which the office is located;

and if the physician agrees to accept the amount determined under section 1833(i)(2)(B) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part.[1]

(b) For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1861.

Payment of Benefits

Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment

[1] Subsec. (a) was amended by sec. 1(a) of P.L. 95-210. Subsec. (a) was further amended by P.L. 96-499 as follows: Subpar. (A) was amended effective with respect to services furnished on or after July 1, 1981 by sec. 930(g); subpar. (B) was amended by sec. 948(a) effective as indicated in the footnote to sec. 1861(b)(7); subpar. (E) was added by sec. 933; and subpar. (F) was added by sec. 934(a).

basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hosptial by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (h) of this section), (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secreary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services, (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge

for such services, and (H) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, and

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and in paragraph (5) of this subsection and unless otherwise specified in section 1881)—

(A) with respect to home health services and to items and services described in section 1861(s)(10), the reasonable cost of such services, as determined under section 1861(v);

(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such costs;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)) exceed 80 percent of such costs;

(4) in the case of facility services described in subparagraph (F) of section 1832(a)(2), the applicable amount described in paragraph (2) of section 1833(i); and

(5) in the case of preadmission diagnostic services described in section 1861(s)(2)(C) which are furnished to an individual by the outpatient department of a hospital within 7 days of such individual's admission to the same hospital as an inpatient or (to the extent practicable as determined by regulations pre-

scribed by the Secretary) to another hospital, the reasonable costs for such services.[1]

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, (2) such total amount shall not include expenses incurred (A) for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, or (B) for items and services described in section 1861(s)(10), (3) such deductible shall not apply with respect to home health services, and (4) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood

[1] Subsec. (a) was amended by sec. 1(b) of P.L. 95–210; see also sec. 1(c) of that law which is printed in this document on p. 802. Subsec. (a) was also amended by secs. 4(b) and 4(c) of P.L. 95–292.

Subsec. (a) was also amended by the following sections of P.L. 96–499: sec. 918(a)(4); sec. 932; sec. 934(d)(1); sec. 942; and sec. 943 (which modified par. (1)(B) effective with respect to services furnished on or after July 1, 1981.) Subsec. (a) was further amended by sec. 1(b)(1) of P.L. 96–611 (which added subpar. (1)(H) effective July 1, 1981).

Section 932(b) of P.L. 96–499 provides as follows:

"(b) The Secretary of Health and Human Services shall transmit to the Congress, no later than one year after the date of the enactment of this Act, a report describing the policy which has been developed and is being or will be implemented with respect to the amendments made by subsection (a)(1) of this section and by section 942 of this title as they concern expenses incurred for preadmission diagnostic testing furnished to an individual at a hospital within seven days of an individual's admission to another hospital."

(or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.[1]

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is the smaller:

(1) $312.50, or

(2) 62½ percent of such expenses.

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).[2]

(h) With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.[3]

(i)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)) or hospital outpatient department, and

[1] Subsec. (b) was amended by sec. 930(h) and 943 of P.L. 96–499 effective with respect to services furnished on or after July 1, 1981 and, effective Dec. 5, 1980, by sec. 934(c)(3) (which added par. (4)). Subsec. (b) was further amended by section 1(b)(2) of P.L. 96–611 which added subpar. (1)(B) effective July 1, 1981.

[2] Subsec. (g) was amended, effective with expenses incurred in calendar years after 1981, by sec. 935 of P.L. 96–499.

[3] Subsec. (h) was redesignated by sec. 6(j) of P.L. 96–473.

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

(2)(A) The amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, and

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(3) In the case of services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with surgical procedures (specified pursuant to paragraph (1) of this subsection) in a physician's office, an

ambulatory surgical center described in such paragraph, or a hospital outpatient department, payment for such services shall be determined in accordance with subsection (a)(1)(G) if the physician accepts an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for such services.

(4)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pursuant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.[1]

Sec. 1834. [Repealed] [2]

Procedure for Payment of Claims of Providers of Services

Sec. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

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[1] Subsec. (i) was added by sec. 934(b) of P.L. 96-499.

[2] Sec. 1834 was repealed by sec. 930(i) of P.L. 96-499 effective with respect to services furnished on or after July 1, 1981.

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physican; [1]

(B) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; and

(C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapy services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physican or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; [2]

[1] Subpar. (A) was amended by sec. 930(j) of P.L. 96-499 effective with respect to services furnished on or after July 1, 1981.

[2] Subpar. (D) was amended by sec. 944 of P.L. 96-499.

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and [1]

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined). With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.[2]

(b)(1) Payment may also be made to any hospital for services described in section 1861(s) furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1814(d)(1)(C) with respect to the calendar year, in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1833(a)(2) and then only if such hospital agrees

[1] Subpar. (E) was added by sec. 933(b) effective with respect to accounting periods beginning on or after July 1, 1981.

[2] The last sentence of subsec. (a) was added by sec. 930(e) of P.L. 96-499 effective with respect to services furnished on or after July 1, 1981.

to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1814(d)(1)(C), to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1833, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Notwithstanding the provisions of this section and sections 1832, 1833, and 1866(a)(1)(A), a hospital may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in secton 1861(s) and furnished to him by such hospital as an outpatient, but only if such charges for such services do not exceed the applicable supplementary medical insurance deductible, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1833(a)(1). Payments

under this title to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position it would have been had it instead been reimbursed in accordance with section 1833(a)(2).

(d) Subject to section 1880, no payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.[1]

(e) For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1861(b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (2) for which the reasonable cost thereof is determined under section 1861(v)(1)(D), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

(1) such hospital has an agreement with the Secretary under section 1866, and

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

Eligible Individuals

Sec. 1836. Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

[1] Subsection (d) was amended by section 401(a) of P.L. 94–437.

Enrollment Periods

Sec. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

(b) [Repealed] [1]

(c) In the case of individuals who first satisfy paragraph (1) or (2) of section 1836 before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on May 31, 1966. For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1836 but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.

(d) In the case of an individual who first satisfies paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1838 as though he had attained such age at that time).

(e) There shall be a general enrollment period which is any period after the period described in subsection (d).[2]

(f) Any individual—

(1) who is eligible under section 1836 to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

[1] Subsec. (b) was repealed, effective with respect to enrollments occurring on or after Apr. 1, 1981, by sec. 945(a) of P.L. 96–499.

[2] Subsec. (e) was amended, effective with respect to enrollments occurring on or after Apr. 1, 1981, by sec. 945(b)(1) of P.L. 96–499.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;[1]

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the month in which the individual files an application establishing such entitlement.[2]

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

[1] Subpar. (1) was amended by sec. 103 of P.L. 96–265.

[2] Par. (3) was amended, effective with respect to enrollments occurring on or after Apr. 1, 1981, by sec. 945(b)(2) of P.L. 96–499.

Coverage Period

Sec. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) July 1, 1966 or (in the case of a disabled individual who has not attained age 65) July 1, 1973, or

(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section 1836, the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the first day of the third month following the month in which he so enrolls; or[1]

(3)(A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or

(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall (except as otherwise provided in section 1843(e)) take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The

[1] Subpar. (E) was amended, effective for enrollments on or after Apr. 1, 1981 by sec. 945(c)(1) of P.L. 96–499.

grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837(f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective and such notice shall not be considered a disenrollment for the purposes of section 1837(b). Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837(f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed.[1]

(c) In the case of an individual satisfying paragraph (1) of section 1836 whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

(d) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

Amounts of Premiums

Sec. 1839. (a) The monthly premium of each individual enrolled under this part for each month before 1968 shall be $3.

(b) (1) The monthly premium of each individual enrolled under this part for each month after 1967 and before July 1, 1973, shall be the amount determined under paragraph (2).

(2) The Secretary shall, during December 1968 and of each year ending on or before December 31, 1971, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 in each succeeding year. Such dollar amount shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such 12-month period will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund

[1] Subsec. (b) was amended by sec. 947(b) of P.L. 96–499, effective for notices filed after March 1981.

for such 12-month period. In estimating aggregate benefits payable for any period, the Secretary shall include an appropriate amount for a contingency margin. Whenever the Secretary, pursuant to the preceding sentence, promulgates the dollar amount which shall be applicable for premiums for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of premiums so promulgated.

(c) (1) The Secretary shall, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such 12-month period. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(2) The monthly premium of each individual enrolled under this part for each month after June 1973 shall, except as provided in subsection (d), be the amount determined under paragraph (3).

(3) The Secretary shall, during December of 1972 and of each year thereafter, determine and promulgate the monthly premium applicable for the individuals enrolled under this part for the 12-month period commencing July 1 in the succeeding year. The monthly premium shall be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that 12-month period, or

(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on May 1 of the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals on the following May 1.[1]

[1] Subparagraph (B) was amended by section 205(e) of P.L. 95–216, effective with respect to social security benefits payable for months after December 1978.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.[1]

(4) The Secretary shall also, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be incurred in the Federal Supplementary Medical Insurance Trust Fund for such 12-month period with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls (2) the months which elapsed between the date of termination of a previous coverage period and the month after the month in which he reenrolled. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.[2]

(e) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(f) For purposes of subsection (c) (and section 1837 (g) (1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which termi-

[1] Subsection (c) (3) was amended by section 104 of Public Law 94-182.

[2] Subsec. (d) was amended, effective with respect to enrollments occurring on or after Apr. 1, 1981, by sec. 945(c) (2) of P.L. 96-499.

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f)) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part;

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part; and

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the

bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year; [1]

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the service is rendered. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the

[1] Subpar. (F) was added, effective with respect to bills submitted or requests for payment made on or after July 1, 1981, by sec. 946(b) of P.L. 96-499.

close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on July 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.[1] [2]

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at anytime (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made

[1] The last sentence of par. (3) was added by sec. 101(a) of P.L. 94-182 subject to limitations specified in sec. 101(b) of that act which is reprinted in this document on page 768.

[2] Par. (3) was amended by secs. 2 and 3 of P.L. 94-368 effective as specified in sec. 4 of that act. Sec. 4 appears in this document on page 778. Par. (3) was also amended by sec. 501(b) of P.L. 95-216 and effective with respect to bills submitted or request for payment made on or after July 1, 1981, by sec. 946(a) of P.L. 96-499.

to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.[1]

(6)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

(i) unless—

(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

(ii) to the extent that the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B)).

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who has a substantial practice outside the teaching setting, the carrier shall take into account

[1] The last sentence of par (5) was added by sec. 2(a)(1) of P.L. 95–142.

the amounts the physician charges for similar services in the physician's outside practice.

(ii) In the case of a physician who does not have a practice described in clause (i), if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greater of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i), or

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients.

(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the carrier shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).[1]

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any pay-

[1] Par. (6) was added by sec. 948(b) of P.L. 96–499.

ment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purpose of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 226(a) of this Act and section 7(d) of the Railroad Retirement Act of 1974.

(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

(B) the amount the laboratory charged the physician for the test,

plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).[1]

State Agreements for Coverage of Eligible Individuals Who Are Receiving Money Payments Under Public Assistance Programs (or Are Eligible for Medical Assistance)

Sec. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981, enter into an agreement with

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[1] Subsec. (h) was added by sec. 918(a)(1) of P.L. 96–499, effective as specified in sec. 918(a)(2). Secs. 918(a)(1) and 918(a)(2) read as follows:

"(2) The amendment made by paragraph (1) shall apply to bills submitted and requests for payment made on or after such date (not later than April 1, 1981) as the Secretary of Health and Human Services prescribes by a notice published in the Federal Register.

"(3) Not later than 24 months after the effective date specified in paragraph (2), the Secretary shall report to the Congress—

"(A) the proportion of bills and requests for payment submitted during the 18-month period beginning on such effective date) under title XVIII of the Social Security Act for laboratory tests which did not identify who performed the tests.

"(B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid under such title was less than the amount that would otherwise have been payable in the absence of section 1842(h) of such Act.

"(C) with respect to requests for payment described in subparagraph (B) which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of such section 1842(h), and

"(D) with respect to bills described in subparagraph (B) which were submitted by physicians, the average reduction in payment per laboratory test to physicians resulting from the application of such section 1842(h)."

such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.[1]

(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under titles I, X, XIV, and XVI, and part A of title IV.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity under the Railroad Retirement Act of 1974. Effective January 1, 1974,

[1] Subsec. (a) was amended by sec. 945(e) of P.L. 96–499.

and subject to section 1902(f), the Secretary shall, at the request of any State not eligible to participate in the State plan program established under title XVI, continue in effect the agreement entered into under this section with such State subject to such modifications as the Secretary may by regulations provide to take account of the termination of any plans of such State approved under titles I, X, XIV, and XVI and the establishment of the supplemental security income program under title XVI.

(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter.

(d) In the case of any individual enrolled pursuant to this section—

(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (c) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his

coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c). The coverage period under this part of any such individual who (in the last month of his coverage period attributable to the State agreement or in any of the following six months) files notice that he no longer wishes to participate in the insurance program established by this part, shall terminate at the close of the month in which the notice is filed.[1]

(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, X, XIV, or XVI or part A of title IV, or eligible to receive medical assistance under the plan of such State approved under title XIX, if the agreement entered into under this section so provides the term "carrier" as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, X, XIV, and XVI, and part A of title IV, and individuals eligible to receive medical assistance under the plan of the State approved under title XIX.

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.[2]

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection.[3]

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible

[1] The last sentence of subsec. (e) was added by sec. 947(a) of P.L. 96–499, effective for notices filed after Mar. 31, 1981. See also sec. 947(e) in excerpts from P.L. 96–499.

[2] Par. (1) was amended by sec. 945(e) of P.L. 96–499.

[3] Par. (2) was amended by sec. 947(c) of P.L. 96–499. See footnote to subsec. (e) above.

to receive medical assistance under the plan of such State approved under title XIX.[1]

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be excluded from the agreement, subsections (c) and (d)(2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d)(2)(C) shall be applied by substituting "second month following the first month" for "first month."

Appropriations to Cover Government Contributions and Contingency Reserve

Sec. 1844. (a) There are authorized to be appropriated from time to time out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) A Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(c)(1) for such month, minus the dollar amount of the premium per enrollee for such month as determined under section 1839(c)(3), to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(c)(4) for such month, minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(c)(3), to

(ii) the dollar amount of the premium per enrollee for such month.

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution represent-

[1] Par. (1) was amended by sec. 945(e) of P.L. 96–499.

ing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

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

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.

Inpatient Hospital Services

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

(1) bed and board;

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

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

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern; and

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

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

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

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.[1]

Inpatient Psychiatric Hospital Services

(c) The term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient Tuberculosis Hospital Services

(d) The term "inpatient tuberculosis hospital services" means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph

[1] Par. (7) was amended by sec. 948(a)(1) of P.L. 96-499, effective as specified in sec. 948(c)(1) which reads:

"(c)(L) The amendments made by subsec. (a) shall apply with respect to cost accounting periods beginning on or after Oct. 1, 1978. A hospital's election under sec. 1861(b)(7)(A) of the Social Security Act (as administered in accordance with sec. 15 of P.L. 93-233) as of Sept. 30, 1978, shall constitute such hospital's election under such section (as amended by subsec. (a)(1)) on and after Oct. 1, 1978, until otherwise provided by the hospital."

(7) of this subsection, and subsection (i) of this section) means an institution which—

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

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

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

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

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

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area; [1]

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

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

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

[1] Par. (5) was amended by sec. 102 of P.L. 94-182.

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

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall pro-

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

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

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i), waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.[1]

[1] The last sentence of subsec. (e) was added by sec. 949 of P.L. 96–499. Subsec. (e) was also amended, effective for services furnished on or after July 1, 1981, by sec. 930(k) of P.L. 96–499.

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A;

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

Tuberculosis Hospital

(g) The term "tuberculosis hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3) and (6)) by such skilled nursing facility—

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

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical, occupational, or speech therapy furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities;

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

Post-Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility—

(A) within 30 days after discharge from such hospital or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital;

an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.[1]

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

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

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

[1] Subsec. (i) was amended by sec. 950 of P.L. 96–499.

(11) complies with the requirements of section 1124;[1]

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

(13) meets such provisions of such edition (as specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes: except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;[2]

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and[3]

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act;

[1] Par. (11) was amended by sec. 3(a)(2) of P.L. 95–142.

[2] Par. (13) was amended by sec. 106(a) of P.L. 94–182 and by sec. 915(a) of P.L. 96–499. Sec. 915(b) of P.L. 96–499 reads as follows:

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

[3] Par. (14) was added by section 21(a) of P.L. 95–142. See also secs. 21 (b) and (c) which are printed in this document on p. 801.

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

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

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

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

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

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

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

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

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

[1] Par. (2) was amended by sec. 951(b) of P.L. 96-499.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

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

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

(2) physical, occupational, or speech therapy;

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

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary; [1]

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

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

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

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

[1] Par. (4) as amended, with respect to services furnished on or after July 1, 1981, by sec. 930(l) of P.L. 96-499.

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

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

Post-Hospital Home Health Services

(n) [Repealed] [1]

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

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

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

(3) maintains clinical records on all patients;

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

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

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; and

(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program; [2]

[1] Subsec. (n) was repealed, effective with respect to services furnished on or after July 1, 1981, by sec. 930(m) of P.L. 96-499.

[2] Par. (7) was added by sec. 930(n)(1) of P.L. 96-499. Sec. 930(s)(2) provides: "(2) The Secretary of Health and Human Services shall take administrative action to assure that improvements, in accordance with the amendment made by subsection (n)(1), will be made not later than June 30, 1981."

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.[1]

Outpatient Physical Therapy Services

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

(1) who is under the care of a physician (as defined in section 1861(r)(1)), and

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

excluding, however—

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

(4) any such service—

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

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

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

(iii) maintains clinical records on all patients,

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

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

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

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsection (s) of this section but only with respect to functions

[1] Subsec. (o) was amended, effective with respect to services furnished on or after July 1, 1981, by sec. 930(n)(2) of P.L. 96-499.

which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(d) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform, or (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to services related to the condition of aphakia, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.[1]

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

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

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

[1] Clauses (2) and (4) were amended, effective with respect to services provided on or after July 1, 1981, by secs. 936(a) and 937(a) of P.L. 96-499. Clause (3) was amended by sec. 951(a) of P.L. 96-499. Sec. 937(b) of P.L. 96-499 provides as follows:

"(b) The Secretary of Health and Human Services shall submit to Congress by January 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act for services furnished by optometrists in connection with cataracts and such services which they are legally authorized to perform."

(C) diagnostic services which are—

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

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

(D) outpatient physical therapy services;

(E) rural health clinic services;[1]

(F) home dialysis supplies and equipment, self-care home dialysis services, and institutional dialysis services and supplies; and[2]

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;[3]

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

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

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

(6) durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased;[4]

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

[1] Subpar. (E) was added by sec. 1(g) of P.L. 95-210.
[2] Subpar. (F) was added by sec. 4(d) of P.L. 95-292.
[3] Subpar. (G) was added by sec. 938 of P.L. 96-499.
[4] Par. (6) was amended by sec. 501(a) of P.L. 95-216.

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices;

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

(10) pneumococcal vaccine and its administration.[1]

No diagnostic tests performed in any laboratory which is independent of a physician's office, a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

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

(12) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.[2]

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

(13) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

(14) is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.[3]

None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t) The term "drugs" and the term "biologicals," except for purposes of subsection (m)(5) of this section, include only such drugs

[1] Par. (10) was added by sec. 1(a) of P.L. 96–611 effective for services furnished on or after July 1, 1981.

[2] This sentence was amended by sec. 1(h) of P.L. 95–210 and by sec. 1(a)(1)(A) of P.L. 96–611.

[3] Pars. (13) and (14) were renumbered by sec. 1(a)(1)(A) of P.L. 96–611.

and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoea, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

Provider of Services

(u) The term "provider of services" means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, detoxification facility, or, for purposes of section 1814(g) and section 1835(e), a fund.[1]

Reasonable Cost

(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers

[1] Subsec. (u) was amended, effective April 1, 1981, by sec. 931(c) of P.L. 96–499 and was further amended, effective with respect to a comprehensive outpatient rehabilitation facility's first account period which begins on or after July 1, 1981, by sec. 933(c) of P.L. 96–499.

the costs determined by the application of this subparagraph (without regard to such clause (ii)).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.[1]

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

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

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

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

except that if the Secretary determines that the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more, such payment shall be made (during such period) on the basis of the reasonable cost of inpatient hospital services.

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

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allow-

[1] Subpar. (F) was added by section 19(b)(1) of P.L. 95-142, effective as specified in sec. 19(c) which is printed in this document on p. 800.

able costs in effect under this title for extended care services provided to patients of such unit.

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

(iv) For the purpose of determining the occupancy rate with respect to hospitals under clause (i)—

(I) public hospital under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

(II) beginning two years after the date this subparagraph is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subparagraph or section 1902(h).[1]

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

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

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

(iii) in the case of contracts entered into by a home health agency after the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract (I) which is entered into for a period exceeding five years, or (II) which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency; and

(iv) in the case of contracts entered into by a home health agency before the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract, which determines the amount payable by the home health

[1] Subpar. (G) was added, effective upon the promulgation of final regulations not later than June 1, 1981, by sec. 902(a)(1) of P.L. 96–499.

agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.[1]

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

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

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary, or upon request to the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.[2]

Certification and Approval of Skilled Nursing Facilities

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatients psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-

[1] Subpar. (H) was added, effective with respect to services furnished on or after July 1, 1981, by sec. 930(p) of P.L. 96–499.

[2] Subpar. (I) was added by sec. 952 of P.L. 96–499.

private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or

services under the authority granted in section 1866(a)(2)(B)(ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organizations, specified in the first sentence of section 1861(p) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment

made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital to patients insured under part A of this title or entitled to have payment made for such services under part B of this title or under a State plan approved under title V or XIX, by a Professional Standards Review Organization designated for the area in which such hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital and such organization under which such hospital is obligated to pay to such organization, as a condition of receiving payment for hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital to such patients.[1]

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 210.

Post-Hospital Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

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

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

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

[1] Paragraph (2) was added by section 112 of P.L. 94-182 and was amended by section 5(m) of P.L. 95-142.

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

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

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

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

Institutional Planning

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

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

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

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

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.[1]

Rural Health Clinic Services

(aa)(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10),[2]

(B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

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

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

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

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

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

[1] Subsec. (2) was amended by sec. 933(d) of P.L. 96-499.

[2] Subpar. (A) was amended by sec. 1(b)(3) of P.L. 96-611 effective July 1, 1981.

physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

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

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

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

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

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

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

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

(3) The term "physician assistant" and the term "nurse practitioner" mean, for the purposes of pargaraphs (1) and (2), a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.[1]

Alcohol Detoxification Facility Services

(bb)(1) The term "alcohol detoxification facility services" means services provided by a detoxification facility in order to reduce or eliminate the amount of alcohol in the body, but only to the extent that such services would be covered under subsection (b) if furnished as inpatient services by a hospital, or are physicians' services covered under subsection (s).

(2) The term "detoxification facility" means a public or voluntary community-based nonprofit facility, other than a hospital, which—

(A) is engaged in furnishing or inpatients the services described in paragraph (1);

(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychiatric Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.[2]

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for

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[1] Subsec. (aa) was added by sec. 1(d) of P.L. 95-210. See also sec. 1(e) of that law which was printed in this document on pp. 802-803.

[2] Subsec. (bb) was added, effective April 1, 1981, by sec. 931(d) of P.L. 96-499. Sec. 931(f) of that Act provides:

"(f) The Secretary of Health and Human Services shall conduct a study and make recommendations, within 18 months after the date of the enactment of this Act, concerning the appropriateness of extending medicare coverage to drug detoxification, postdetoxification rehabilitation, and to outpatient detoxification and concerning incentives for the use of lower-cost detoxification facilities."

furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

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

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

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

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

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

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

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

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

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.[1]

Exclusions From Coverage

Sec. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or, in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness;[2]

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1861(aa)(1), and in such other cases as the Secretary may specify;[3]

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

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[1] Subsec. (cc) was added by sec. 933(e) of P.L. 96–499 effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after July 1, 1981.

[2] Par. (1) was amended by sec. 1(a)(2)(A) of P.L. 96–611.

[3] Par. (3) was amended by sec. 1(b) of P.L. 95–210.

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and paragraph (1));[1]

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care;

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, or because of the severity of the dental procedure,, requires hospitalization in connection with the provision of such services; or[2]

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns, or calluses, the trimming of nails, and other routine hygienic care).[3]

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance. Any payment under this

[1] Par. (7) was amended by sec. 1(a)(3)(B) of P.L.96–611.

[2] Par. (12) was amended by sec. 936(c) of P.L. 96–499 effective with respect to services provided on or after July 1, 1981. The double comma is a technical error.

[3] Par. (13) was amended by sec. 939 of P.L. 96–499 effective with respect to services provided on or after July 1, 1981.

title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan, policy, plan, or insurance. The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.[1]

(c) [Repealed.][2]

(d)(1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or[3]

(C) has furnished services or supplies which are determined by the Secretary, on the basis of reports transmitted to him in accordance with section 1157 of this Act (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this title), to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.[4]

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, posthospital extended care services, and home health services such determination shall be effective in the manner provided in section 1866(b)(3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable

[1] Subsec. (b) was amended by sec. 953 of P.L. 96–499.

[2] Subsec. (c) was repealed by sec. 103 of P.L. 94–182.

[3] Subpar. (B) was amended by sec. 13(b)(1) of P.L. 95–142.

[4] Subpar. (C) was amended by sec. 13(b)(2) of P.L. 95–142.

notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(4) The Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of any determination made under the provisions of this subsection.[1]

(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1128 from participation in the program under this title.[2]

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[1] Par. (4) had been struck out by sec. 13(a) of P.L. 95–142. New par. 4 was added by sec. 308 of P.L. 96–272.

[2] Subsec. (e) was amended by sec. 913(b) of P.L. 96–499.

Consultation With State Agencies and Other Organizations To Develop Conditions of Participation for Providers of Services

Sec. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (g)(4), (j)(11), (o)(6), and (cc)(2)(I) of section 1861, or by ambulatory surgical centers under section 1832(a)(2)(F)(i), the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.[2]

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

Sec. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of

[1] Subsec. (e) was added by sec. 7(a) of P.L. 95–142.
[2] Sec. 1863 was amended by secs. 933(f) and 934(c)(1) of P.L. 96–499.

determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2) or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2), or whether a laboratory meets the requirements of paragraphs (11) and (12) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization.[1]

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable

[1] Subsec. (a) was amended by sec. 1(i) of P.L. 95–210, by secs. 933(g) and 934(c)(2) of P.L. 96–499, and by sec. 1(a)(2) of P.L. 96–611.

to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which

performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), hospitals which have an agreement with the Secretary under section 1866 and which are accredited by the Joint Commission on the Accreditation of Hospitals. The Secretary shall pay for such services in the manner prescribed in subsection (b).

Effect of Accreditation

Sec. 1865. (a) Except as provided in subsection (b) and the second sentence of section 1863, if—

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2) such institution (if it is included within a survey described in section 1864(c)) authorizes the Commission to release to the Secretary (on a confidential basis) upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose) or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with section 1861(e)(6) or the standard described in such paragraph (4), as the case may be. In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1861 (e), (j), or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

(b) Notwithstanding any other provision of this title, if the Secretary finds following a survey made pursuant to section 1864(c) that an institution has significant deficiencies (as defined in regulations pertaining to health and safety), such institution shall, after the date of notice of such finding to the hospital and for such period as may be prescribed in regulations, be deemed not to meet the requirements of the numbered paragraphs of section 1861(e).

Agreements With Providers of Services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.[1]

An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to

[1] Subparagraph (D) was added by section 15 of P.L. 95-142.

such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10) for which payment is made under part B.[1]

(B)(i) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(ii) Where a provider of services customarily furnishes an individual items or services which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services under this title and which have not been requested by such individual, such provider may (except with respect to emergency services) also charge such individual or other person for such more expensive items or services to the extent that the costs of (or, if less, the customary charges for) such more expensive items or services experienced by such provider in the second fiscal period immediately preceding the fiscal period in which such charges are imposed exceed the cost of such items or services determined to be necessary in the efficient delivery of needed health services, but only if—

[1] Subpar. (A) was amended by sec. 4(e) of P.L. 95–292, effective as specified in sec. 6 of that act, which is printed in this document on p. 810 and was further amended by sec. 1(b)(4) of P.L. 96–611.

ices) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

(4)(A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

(5) with respect to any other items and services furnished on or after the effective date of such termination.

(c)(1) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

(2) In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910(a), and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.[1]

(3) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination.[2]

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and

[1] Par. (2) was amended by sec. 2(e) of P.L. 95–210.
[2] Par. (3) was added by sec. 308 of P.L. 96–272.

the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined).

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under such title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiences, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month

such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secetary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.[1]

Health Insurance Benefits Advisory Council

Sec. 1867. (a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or con-

[1] Subsec. (f) was added by sec. 916(a) of P.L. 96–499.

ferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.

(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.

Sec. 1868. [Repealed.]

Determinations; Appeals

Sec. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818, or section 1819, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero).

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent);

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent); or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who furnished the services do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.[1]

(g) If an individual, who is enrolled under section 1818(c) of the Social Security Act or under section 1837, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

Regulations

Sec. 1871. The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

[1] Subsec. (f) was amended by sec. 954 of P.L. 96–499.

Application of Certain Provisions of Title II

Sec. 1872. The provisions of sections 206 and 216(j), and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(k) Each health maintenance organization with which the Secretary enters into a contract under this section shall have an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of subsection (h)) or would result in enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.[1]

Penalties[2]

Sec. 1877. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a mis-

[1] Subsection (k) was added by section 201(d) of P.L. 94-460.
[2] Section 1877 was amended, in its entirety, by section 4(a) of P.L. 95-142.

demeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or items for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.[1]

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

[1] Subsec. (b) was amended by sec. 917 of P.L. 96–499.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defind in section 1861), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever accepts assignments described in section 1842(b)(3)(B)(ii) and knowingly, willfully, and repeatedly violates the term of such assignments specified in subclause (I) of such section, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

Provider Reimbursement Review Board

Sec. 1878. (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h), if—

(1) such provider—

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after a notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate $50,000 or more.

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissable under rules of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 205 with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

(f) (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.[1]

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a) (3) and equal to the rate of return on equity capital established by regulation pursuant to section 1861(v)(1)(B) and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this Act.

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[1] Par. (1) was amended by sec. 955 of P.L. 96–499.

(g) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of cost reimbursement, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS–18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

Limitation on Liability of Beneficiary Where Medicare Claims Are Disallowed

Sec. 1879. (a) Where—

(1) a determination is made that, by reason of section 1862(a)(1) or (9), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section 1862(a)(9) did not apply. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising

thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services.

(b) In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs), subject to the deductible and coinsurance provisions of this title, for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services.

(c) No payments shall be made under this title in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1862(a)(1) or (a)(9).

(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under section 1869(b) (when the determination is under part A) or section 1842(b)(3)(C) (when the determination is under part B) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of section 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary shall take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.[1]

[1] Subsec. (e) was added by sec. 956 of P.L. 96–499.

Indian Health Service Facilities

Sec. 1880. (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 408 of such Act) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.[1]

[1] Section 1880 was added by section 401(b) of P.L. 94-437 subject to the limitation in section 401(c)-401(d) of that act. These provisions are printed in this document on page 781.

(e)(1) Notwithstanding any other provision of this title, the Secretary may, pursuant to agreements with approved providers of services, renal dialysis facilities, and nonprofit entities which the Secretary finds can furnish equipment economically and efficiently, reimburse such providers, facilities and nonprofit entities (without regard to the deductible and coinsurance provisions of this title) for the reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent use of artificial kidney and automated dialysis peritoneal machines (including supportive equipment) which are to be used exclusively by entitled individuals dialyzing at home.

(2) An agreement under this subsection shall require that the provider or facility, or other entity will—

(A) make the equipment available for use only by entitled individuals dialyzing at home;

(B) recondition the equipment, as needed, for reuse by such individuals throughout the useful life of the equipment, including modification of the equipment consistent with advances in research and technology;

(C) provide for full access for the Secretary to all records and information relating to the purchase, maintenance, and use of the equipment; and

(D) submit such reports, data, and information as the Secretary may require with respect to the cost, management, and use of the equipment.

(3) For purposes of this section, the term "supportive equipment" includes blood pumps, heparin pumps, bubble detectors, other alarm systems, and such other items as the Secretary may determine are medieally necessary.[1]

(f)(1) The Secretary shall initiate and carry out, at selected locations in the United States, pilot projects under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end stage renal disease at the time home dialysis is begun, with provision for a trial period to assure successful adaptation to home dialysis before the actual purchase of such equipment.

(2) The Secretary shall conduct experiments to evaluate methods for reducing the costs of the end stage renal disease program. Such experiments shall include (without being limited to) reimbursement for nurses and dialysis technicians to assist with home dialysis, and reimbursement to family members assisting with home dialysis.

(3) The Secretary shall conduct experiments to evaluate methods of dietary control for reducing the costs of the end stage renal disease program, including (without being limited to) the use of protein-controlled products to delay the necessity for, or reduce the frequency of, dialysis in the treatment of end stage renal disease.

[1] Subsec. (e) was amended by sec. 957(a) of P.L. 96-499.

(4) The Secretary shall conduct a comprehensive study of methods for increasing public participation in kidney donation and other organ donation programs.

(5) The Secretary shall conduct a full and complete study of the reimbursement of physicians for services furnished to patients with end stage renal disease under this title, giving particular attention to the range of payments to physicians for such services, the average amounts of such payments, and the number of hours devoted to furnishing such services to patients at home, in renal disease facilities, in hospitals, and elsewhere.

(6) The Secretary shall conduct a study of the number of patients with end stage renal disease who are not eligible for benefits with respect to such disease under this title (by reason of this section or otherwise), and of the economic impact of such noneligibility of such individuals. Such study shall include consideration of mechanisms whereby governmental and other health plans might be instituted or modified to permit the purchase of actuarially sound coverage for the costs of end stage renal disease.

(7) The Secretary shall conduct a study of the medical appropriateness and safety of cleaning and reusing dialysis filters by home dialysis patients. In such cases in which the Secretary determines that such home cleaning and reuse of filters is a medically sound procedure, the Secretary shall conduct experiments to evaluate such home cleaning and reuse as a method of reducing the cost of the end stage renal disease program.

(8) The Secretary shall submit to the Congress no later than October 1, 1979, a full report on the experiments conducted under paragraphs (1), (2), (3), and (7), and the studies under paragraphs (4), (5), (6), and (7). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of such experiments and studies.

(g) The Secretary shall submit to the Congress on July 1, 1979, and July 1 of each year thereafter a report on the end stage renal disease program, including but not limited to—

(1) the number of patients, nationally and by renal disease network, on dialysis (self-dialysis or otherwise) at home and in facilities;

(2) the number of new patients entering dialysis at home and in facilities during the year;

(3) the number of facilities providing dialysis and the utilization rates of those facilities;

(4) the number of kidney transplants, by source of donor organ;

(5) the number of patients awaiting organs for transplant;

(6) the number of transplant failures;

(7) the range of costs of kidney acquisitions, by type of facility and by region;

(8) the number of facilities providing transplants and the number of transplants performed per facilitity;

(9) patient mortality and morbidity rates;

(10) the average annual cost of hospitalization for ancillary problems in dialysis and transplant patients, and drug costs for transplant patients;

(11) medicare payment rates for dialysis, transplant procedures, and physician services, along with any changes in such rates during the year and the reasons for those changes;

(12) the results of cost-saving experiments;

(13) the results of basic kidney disease research conducted by the Federal Government, private institutions, and foreign governments.

(14) information on the activities of medical review boards and other networks organizations; and

(15) estimated program costs over the next five years.[1]

Voluntary Certification of Medicare Supplemental Health Insurance Policies[2]

Sec. 1882. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(b)(1) Any medicare supplemental policy issued in any State

[1] Subsec. (e) was amended by sec. 957(b) of P.L. 96-499.
[2] Sec. 1882 was added by sec. 507 of P.L. 96-265.

which the Supplemental Health Insurance Panel (established under paragraph (2)) determines has established under State law a regulatory program that—

(A) provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

(B) includes a requirement equal to or more stringent than the requirement described in subsection (c)(2); and

(C) provides for application of the standards and requirements described in subparagraphs (A) and (B) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State.

shall be deemed (for so long as the Panel finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c).

(2)(A) There is hereby established a panel (hereinafter in this section referred to as the "Panel") to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the President and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.

(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph.

(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards; and

(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period

the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.

Hospital Providers of Extended Care Services

Sec. 1883. (a)(1) Any hospital (other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilites may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services, (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

(I) the number of patient-days during the year for which the services were furnished, and

(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under the State plan (of the State in which the hospital is located) under title XIX to skilled nursing facilities located in the State and which meet the requirements specified in section 1902(a)(28), or, in the case of a hospital located in a State which does not have such a State plan, the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing facilities in such State.

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(b) The Secretary may not enter into an agreement under this section with any hospital unless—

(1) except as provided under subsection (g), the hospital is located in a rural area and has less than 50 beds, and

(2) the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or during which there is in effect for the hospital a waiver under subparagraph (A) of the last sentence of section 1861(e). A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d) Any agreeemnt with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary may enter into an agreement under this section on a demonstration basis with any hospital which does not meet the requirement of subsection (b)(1), if the hospital otherwise meets the requirements of this section.[1]

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[1] Sec. 1833 was added by sec. 904(a) of P.L. 96–499 effective upon the promulgation of final regulations no later than June 1, 1981. See sec. 904(c) in excerpts from P.L. 96–499 for evaluation requirement.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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Appropriation

Sec. 1901. For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the cost of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

State Plans for Medical Assistance [2]

Sec. 1902. (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds

[1] This table of contents does not appear in the law.

[2] In addition to the requirements of this section, State medical assistance plans must comply with the requirements of section 212(a) of P.L. 93–66 (see page 742 of this document); sec. 503 of P.L. 94–566 (see page 792 of this document) and sec. 1618 of the Social Security Act.

from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

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

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI or by the agency or agencies administering the supplemental security income program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

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

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purposes specified in the first sentence of section 1864 (a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;

(10) provide—[1]

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

[1] P.L. 92-603, sec. 249E, provides: "For purposes of section 1902(a)(10) of the Social Security Act any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act and who for such month was entitled to monthly insurance benefits under title II of such Act shall be deemed to be eligible for such aid or assistance for any month thereafter prior to July 1975 if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under title II of such Act resulting from enactment of Public Law 92-336 not been applicable to such individual."

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, and (B) effective July 1, 1969, provide, to the

extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under title V and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1903;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) (i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), and [1]

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or

(ii) (I) the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and [1]

(D) (i) for payment (except where the State agency is subject to an order under section 1914) of the reasonable cost of inpatient hospital services provided under the plan, as

[1] Subpars. (B) and (C) were amended, effective July 1, 1981, by sec. 965(b) of P.L. 96-499. See excerpt from that Act for deferred effective date (sec. 965(c)(2)) for States requiring legislation.

determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section, and (ii) for payment of the reasonable cost of inappropriate inpatient services (described in subsection (h)(1)) for which payment is provided only because of subsection (h) at the rate of payment for such services provided for under such subsection.[1]

(E) for payment (except where the State agency is subject to an order under section 1914) of the skilled nursing facility and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each skilled nursing or intermediate care facility and periodic audits by the State of such reports; and [2]

(F) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph; [3]

[1] Subpar. (D) was amended by sec. 903(b) of P.L. 96–499 and, effective upon the promulgation of final regulations not later than July 1, 1981, by sec. 902(b)(1) of P.L. 96–499. The period at the end of subpar. (D) apparently should be a "; and".

[2] Subpar. (E) was amended, effective Oct. 1, 1980, by sec. 962 of P.L. 96–499 and was further amended by sec. 905(a) of P.L. 96–499.

[3] Subpar. (F) was added by sec. 2(c)(1) of P.L. 95–210 effective as specified in sec. 2(f) which is printed in this document on p. 803.

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in paragraphs (1) through (5), (7), and (17) of section 1905(a), will be imposed under the plan, and [1]

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental security income benefits are not being paid under title XVI and who do not meet the income and resources requirements of the appropri-

[1] Clause (i) was amended, effective July 1, 1981, by sec. 965(b)(4) of P.L. 96–499. See sec. 965(c)(2), in excerpts from P.L. 96–499, for deferred effective date for States requiring legislation.

ate State plan, or the supplemental security income program under title XVI, as the case may be,

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation

of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program)) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements

or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connnection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment; [1]

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determin-

[1] Paragraph (32) was amended by sec. 2(a)(3) of P.L. 95–142.

ing whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation; [1]

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124; [2]

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect

[1] Subpar. (B) was amended by sec. 916(b)(1)(B) of P.L. 96-499.

[2] Par. (35) was amended by sec. 3(c)(1)(A) of P.L. 95-142 and by sec. 912(b) of P.L. 96-499.

to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.[1]

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.[2]

(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period; [3]

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization; [4]

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action; [5]

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent

[1] Par. (37) was added by sec. 2(b) of P.L. 95-142.

[2] Par. (38) was added by sec. 3(c)(1)(D) of P.L. 95-142.

[3] Par. (39) was added by sec. 7(b) of P.L. 95-142 and was amended by sec. 913(c) of P.L. 96-499.

[4] Par. (40) was added by sec. 19(b)(2) of P.L. 95-142.

[5] Par. (41) was added by sec. 308 of P.L. 96-272.

and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).[1]

(43) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).[2]

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1903(i)(4), the term "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title

[1] Par. (42) was added by sec. 914(b)(1) of P.L. 96-499, effective April 1, 1981. See sec. 914(b)(2), in excerpts from P.L. 96-499, for deferred effective date for States requiring legislation.

[2] Par. (43) was added by sec. 918(b)(1) of P.L. 96-499, effective July 1, 1981. See sec. 918(b)(2), in excerpts from P.L. 96-499, for deferred effective date for States requiring legislation.

II resulting from enactment of Public Law 92-336 not been applicable to such individual.[1]

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.[2]

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

(1) an age requirement of more than 65 years; or

(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 406(a)(2), be a dependent child under part A of subchapter IV of this chapter; or

(3) any residence requirement which excludes any individual who resides in the State; or

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

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this title, attributable to medical

[1] This sentence was added by P.L. 94-48.

[2] This sentence was added by sec. 2(b)(1)(D) of P.L. 95-142.

needs) provided for eligible individuals under a plan of such State approved under title I, X, XIV, or XVI, or part A of title IV.

(d) [Repealed].

(e) Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individ-

ual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection.

(g) [Repealed] [1]

(h)(1) In any case in which a hospital provides inpatient services to an individual that would constitute skilled nursing facility services if provided by a skilled nursing facility or that would constitute intermediate care facility services if provided by an intermediate care facility and a Professional Standards Review Organization (or, in the absence of such a qualified organization, an organization or agency with review responsibility as is otherwise provided for under part A of title XI) determines that inpatient hospital services for the individual are not medically necessary but skilled nursing facility services or intermediate care facility services, respectively, for the individual are medically necessary and such type of facility services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for inpatient hospital services shall continue to be made under the State plan approved under this title at the payment rate described in paragraph (2) for such type of services during the period in which—

(A) such skilled nursing facility services or intermediate care facility services (as the case may be) for the individual are medically necessary and not otherwise available to the individual (as so determined),

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

(C) the individual is entitled to receive medical assistance with respect to such facility services under the State plan,

except that if the Secretary determines that the hospital had (during the immediately preceding calendar year) an average daily occupancy rate of 80 percent or more, such payment shall be made (during such period) on the same basis as otherwise used under the State's plan for payments for providing inpatient hospital services.

(2)(A) Except as provided in subparagraph (B), the payment rate referred to in paragraph (1), in the case of skilled nursing facility services or intermediate care facility services, is the estimated adjusted State-wide average rate per patient-day paid for such respective type of services provided under the State plan.

(B) If a hospital has a unit which is a skilled nursing facility or intermediate care facility, the payment rate referred to in paragraph (1), in the case of inpatient services which constitute skilled nursing facility services or intermediate care facility services, is a rate equal to the lesser of the rate described in subparagraph (A) or the allowable costs in effect under the State plan for such type of inpatient services provided to patients of such unit.

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

(4) For the purpose of determining the occupancy rate with respect to hospitals under paragraph (2)—

(A) public hospitals under common ownership may elect (with the approval of the Secretary) to be treated as a single hospital, and

(B) beginning two years after the date this subsection is first applied with respect to a hospital, the Secretary, to the extent feasible, shall not treat as an inpatient an individual with respect to whom payment is made to the hospital only because of this subsection or section 1861(v)(1)(G).[1]

(i)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, follow-

[1] Subsec. (g) was added by sec. 111 of P.L. 94-182 and repealed by P.L. 94-552. A new subsec. (g) was added by sec. 7(c) of P.L. 95-142 and was repealed by sec. 913(d) of P.L. 96-499.

[1] Subsec. (h) was added by sec. 902(b)(2) of P.L. 96-499, effective upon the promulgation of final regulations not later than June 1, 1981.

ing the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.[1]

(j)(1) Notwithstanding any other provision of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act.

(2) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationshp to such uncompensated value.

(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c).[2]

[1] Subsec. (i) was added by sec. 916(b)(1)(A) of P.L. 96–499.

[2] Subsec. (j) was added by sec. 5(b) of P.L. 96–611.

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g), (h), and (j) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus [1]

[1] Par. (1) was amended by sec. 905(b) of P.L. 96–499.

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel of the State agency or any other public agency; plus

(3) an amount equal to—

(A) (i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A) (i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus [1]

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found neces-

[1] Subparagraph (B) was amended by sec. 10 of P.L. 95-142.

sary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus [1]

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus [2]

(7) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.[2]

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or

[1] Par. (4) is effective only through Sept. 30, 1980 as provided by sec. 249B of P.L. 92–603, as amended by sec. 8 of P.L. 93–368 and sec. 309(b) of P.L. 95–83.

[2] Par. (6) was added (and the former par. (6) was redesignated as par. (7)) by sec. 17(a) of P.L. 95–142. See also sec. 17(e) which is printed in this document on p. 799. Par. (6) was amended by sec. 963 of P.L. 96–499.

areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) $125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.[1]

(c) [Repealed.]

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the

[1] Par. (3) was added by sec. 17(b) of P.L. 95–142.

amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination (but not to exceed a period of twelve months with respect to disallowances made prior to October 1, 1981, or six months with respect to disallowances made thereafter) at the rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during such period.[1]

(e) [Repealed.]

(f) (1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

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[1] Par. (5) was added by sec. 961 of P.L. 96–499.

(B) (i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan (without regard to section 408) provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

State agency required under this subsection) shall be made available for public inspection.[1]

(3) (A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).[2]

(4) (A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraph (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

[1] Par. (2) was amended by sec. 20(a)(3) of P.L. 95–142.

[2] Par. (3) was added by sec. 20(a)(4) of P.L. 95–142 effective as specified in sec. 20(c) which is printed in this document on p. 801. Par. (3) was amended by sec. 964 of P.L. 96–499.

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due deligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.[1]

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.[1]

(6) The Secretary shall submit to Congress, not later than sixty days after the end of such calendar quarter, a report on—

(A) his determination as to whether or not each showing made under paragraph (1) by a State with respect to the calendar quarter, has been found to be satisfactory under such paragraph;

(B) his review (through onsite surveys and otherwise) under paragraph (2) of the validity of showings previously submitted by a State; and

(C) any reduction in the Federal medical assistance percentage he has imposed on a State because of its submittal under paragraph (1) of an unsatisfactory or invalid showing.[1]

(h)(1) If the Secretary determines for any calendar quarter beginning after June 30, 1973, with respect to any State that there does not exist a reasonable cost differential between the statewide average cost of skilled nursing facility services and the statewide average cost of intermediate care facility services in such State, the Secretary may reduce the amount which would otherwise be considered as expenditures under the State plan by any amount which in his judgment is a reasonable equivalent of the difference between the amount of the expenditures by such State for intermediate care facility services and

[1] Paragraphs (4), (5), and (6) were added by sec. 20(a)(4) of P.L. 95-142 effective as specified in sec. 20(c) which is printed in this document on p. 801.

the amount that would have been expended by such State for such services if there had been a reasonable cost differential between the cost of skilled nursing facility services and the cost of intermediate care facility services.

(2) In determining whether any such cost differential in any State is reasonable the Secretary shall take into consideration the range of such cost differentials in all States.

(3) For the purposes of this subsection, the term "cost differential" for any State for any quarter means, as determined by the Secretary on the basis of the data for the most recent calendar quarter for which satisfactory data are available, the excess of—

(A) the average amount paid in such State (regardless of the source of payment) per inpatient day for skilled nursing facility services, over

(B) the average amount paid in such State (regardless of the source of payment) per inpatient day for intermediate care facility services.

(4) For purposes of this subsection, the term "cost" shall mean amounts reimbursable by the State under a State plan approved under this title.

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or[1]

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items

[1] Paragraph (2) was amended by sec. (3)(c)(2) of P.L. 95-142.

(specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.[1]

[1] Subsec. (j) was amended by sec. 905(c)(1) of P.L. 96–499.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of section 1876 for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

(l) [Repealed] [1]

(m)(1)(A) The term "health maintenance organization" means a legal entity which provides health services to individuals enrolled in such organization and which—

(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act (except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits de-

[1] Sub. (1) added by sec. 111 of P.L. 94–182 and repealed by P.L. 94–552.

scribed in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)); and

(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a)(1), (2), (3), (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1); and

(ii) less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title.[1]

(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 319(d)(1)(A) or 330(d)(1)

[1] Subparagraph (A) was amended by sec. 105(a)(1) of P.L. 95-83.

of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).[1]

(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for

[1] Subpar. (C) was amended by sec. 105(a)(2) of P.L. 95-83 and by sec. 128 of P.L. 96-79.

which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).[1]

(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 of this section); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.[2]

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.[3]

(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

[1] Subsec. (m) was added by sec. 202 of P.L. 94–460.

[2] Subsec. (n) was added by sec. 8(c) of P.L. 95–142 and was amended by sec. 905(c)(2) of P.L. 96–499. The words "of this section" in the second parenthetical are apparently a technical error and should have been deleted.

[3] Subsec. (o) was added by sec. 11(a) of P.L. 95–142.

Operation of State Plans

Sec. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

Definitions

Sec. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

(i) under the age of 21,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, or

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)) and which are otherwise included in the plan; [1]

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1861(r)(1)), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

[1] Par. (2) was amended by sec. 2(a) of P.L. 95–210 effective as specified in sec. 2(f) which is printed in this document on p. 803.

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);

(17) services furnished by a nurse-midwife (as defined in subsection (m)) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and [1]

(18) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the

[1] Par. (17) was added (and former (17) was redesignated as (18)) by sec. 965(a)(1) of P.L. 96–499 effective July 1, 1981. See sec. 965(c), in excerpts from P.L. 96–499, for deferred effective date for States requiring legislation.

spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1101(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).[1]

(c) For purposes of this title the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, (2) meets such standards prescribed by the Secretary as he finds appropriate for the proper provision of such care, (3) meets such standards of safety and sanitation as are established under regulation of the Secretary in addition to those applicable to nursing homes under State law, and (4) meets the requirements of section 1861(j)(14) with respect to protection of patients' personal funds. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist,

[1] The last sentence of subsection (b) was added by section 402(e) of P.L. 94-437.

(j) The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under title XVI or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Secretary), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under title XVI, or would but for his income be payable under that title.

(k) Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under title XVI.

(l) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1861(aa), except that (1) clause (ii) of section 1861(aa)(2) shall not apply to such terms, and (2) the physician arrangement required under section 1861(aa)(2)(B) shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.[1]

(m) The term "nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.[2]

Sec. 1906. [Repealed.]

Observance of Religious Beliefs

Sec. 1907. Nothing in this title shall be construed to require any State which has a plan approved under this title to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, his parent or guardian objects) thereto on religious grounds.

[1] Sub. (l) was added by sec. 2(b) of P.L. 95-210 effective as specified in sec. 2(f) which is printed in this document on p. 803.
[2] Subsec. (m) was added by sec. 965(a)(2) of P.L. 96-499.

State Programs for Licensing of Administrators of Nursing Homes

Sec. 1908. (a) For purposes of section 1902(a)(29), a "State program for licensing of administrators of nursing homes" is a program which provides that no nursing home within the State may operate except under the supervision of an administrator licensed in the manner provided in this section.

(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of chronically ill and infirm aged patients and established to carry out the purposes of this section.

(c) It shall be the function and duty of such agency or board to—

(1) develop, impose, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator, which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators;

(2) develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets such standards;

(3) issue licenses to individuals determined, after the application of such techniques, to meet such standards, and revoke or suspend licenses previously issued by the board in any case where the individual holding any such license is determined substantially to have failed to conform to the requirements of such standards;

(4) establish and carry out procedures designed to insure that individuals licensed as nursing home administrators will, during any period that they serve as such, comply with the requirements of such standards;

(5) receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the board to the effect that any individual licensed as a nursing home administrator has failed to comply with the requirements of such standards; and

(6) conduct a continuing study and investigation of nursing homes and administrators of nursing homes within the State with a view to the improvement of the standards imposed for the licensing of such administrators and of procedures and methods for the enforcement of such standards with respect to administrators of nursing homes who have been licensed as such.

(d) No State shall be considered to have failed to comply with the provisions of section 1902(a)(29) because the agency or board of such State (established pursuant to subsection (b)) shall have granted any waiver, with respect to any individual who, during all of the three calendar years immediately preceding the calendar year in which the requirements prescribed in section 1902(a)(29) are first met by the State, has served as a nursing home administrator, of any of the standards developed, imposed, and enforced by such agency or board pursuant to subsection (c).

(e) As used in this section, the term—

(1) "nursing home" means any institution or facility defined as such for licensing purposes under State law, or, if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary, but does not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts; and

(2) "nursing home administrator" means any individual who is charged with the general administration of a nursing home whether or not such individual has an ownership interest in such home and whether or not his functions and duties are shared with one or more other individuals.

Penalties [1]

Sec. 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years

[1] Section 1909 was amended in its entirety by sec. 4(b) of Public Law 95-142.

or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) (1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.[1]

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.[1]

(3) Paragraphs (1) and (2) shall not apply to—

[1] Par. (1) and (2) were amended by sec. 917 of P.L. 96-499.

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Certification and Approval of Skilled Nursing Facilities and of Rural Health Clinics[1]

Sec. 1910. (a)(1) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes

[1] Sec. 1910 was amended by sec. 2(d) of P.L. 95–210 effective as specified in sec. 2(f)

an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.[1]

Indian Health Service Facilities[2]

Sec. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

Assignment of Rights of Payment[3]

Sec. 1912. (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance may—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party; and

[1] Subsec. (c) was added by sec. 916(b)(2) of P.L. 96–499.

[2] Sec. 1911 was added by sec. 402(a) of P.L. 94–437 subject to the conditions specified in sec. 402(b)–402(d) of that act which are printed in this document on page 782.

[3] Sec. 1912 was added by sec. 11(b) of P.L. 95–142.

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

Hospital Providers of Skilled Nursing and Intermediate Care Services [1]

Sec. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1883.

(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to skilled nursing and intermediate care facilities, respectively, located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same

[1] Sec. 1913 was added by sec. 904(b) of P.L. 96–499 effective upon promulgation of final regulations not later than June 1, 1981. See sec. 904(c), in excerpts from P.L. 96–499, for evaluation requirement.

manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1883, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

Withholding of Federal Share of Payments for Certain Medicare Providers [1]

Sec. 1914. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

[1] Sec. 1914 was added by sec. 905(d) of P.L. 96–499.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

or the geographic area in which the services with respect to which the contribution is used are to be provided, except that during fiscal years 1980 and 1981 the provisions of this clause shall not apply with respect to funds that are donated for the purpose of training or retraining as provided in subsection (a)(1), if such training or retraining is carried out by a public or nonprofit entity, and [1]

(iii) do not revert to the donor's facility or use if the donor is other than a nonprofit organization; or

(E) for the provision of room or board (except as provided by paragraph (11)(C) and paragraph (11)(D)[2]) other than room or board provided for a period of not more than six consecutive months as an integral but subordinate part of a service described in paragraph (1) of this subsection.

With regard to ending the dependency of individuals who are alcoholics or drug addicts, the entire rehabilitative process for such individuals, including but not limited to initial detoxification, short term residential treatment, and subsequent outpatient counseling and rehabilitative services, whether or not such a process involves more than one provider of services, shall be the basis for determining whether standards imposed by or under subparagraph (A) or (E) of this paragraph have been met.[3]

(8) No payment may be made under this section with respect to any expenditure if payment is made with respect to that expenditure under section 403 or 423 of this Act.[4]

(9)(A) No payment may be made under this section with respect to any expenditure in connection with the provision of any child day care service, unless—

(i) in the case of care provided in the child's home, the care meets standards established by the State which are reasonably in accord with recommended standards of national standard-setting organizations concerned with the home care of children, or

(ii) in the case of care provided outside the child's home, the care meets the Federal interagency day care requirements as ap-

[1] Clause (ii) was amended by sec. 204 of P.L. 96–272.

[2] The phrase "and par. 11(D)" was added by sec. 4 of P.L. 94–120 as amended by sec. 6 of P.L. 94–401, by sec. 1(c) of P.L. 95–171, sec. 5 of P.L. 96–178, and sec. 209 of P.L. 96–272.

[3] The last sentence of par. (7) was added by sec. 4 of P.L. 94–120 as amended by sec. 6 of P.L. 94–401, by section (c) of P.L. 95–171, sec. 5 of P.L. 96–178, and sec. 209 of P.L. 96–272.

[4] This section reference was amended by sec. 103 of P.L. 96–272.

proved by the Department of Health, Education, and Welfare and the Office of Economic Opportunity on September 23, 1968; except that (I) subdivision III of such requirements with respect to educational services shall be recommended to the States and not required, and staffing standards for school-age children in day care centers may be revised by the Secretary, (II) the staffing standards imposed with respect to such care in the case of children under age 3 shall conform to regulations prescribed by the Secretary, and (III) the staffing standards imposed with respect to such care in the case of children aged 10 to 14 shall require at least one adult for each 20 children, and in the case of school-aged children under age 10 shall require at least one adult for each 15 children, except as provided in subparagraph (B).[1]

(B) The Secretary shall submit to the President of the Senate and the Speaker of the House of Representatives, after December 31, 1976, and prior to April 1, 1978, an evaluation of the appropriateness of the requirements imposed by subparagraph (A), together with any recommendations he may have for modification of those requirements. No earlier than ninety days after the submission of that report, the Secretary may, by regulation, make such modifications in the requirements imposed by subparagraph (A) as he determines are appropriate.[2]

(C) The requirements imposed by this paragraph are in lieu of any requirements that would otherwise be applicable under section 522(d) of the Economic Opportunity Act of 1964 to child day care services with respect to which payment is made under this section.

(D) The requirements imposed by this paragraph or by any regulations promulgated by the Department of Health and Human Services to carry out this paragraph shall be inapplicable to child day care services provided after June 30, 1980, and prior to July 1, 1981, which meet applicable standards of State and local law.[3]

(10) No payment may be made under this section with respect to any expenditure for the provision of any educational service which

[1] The requirements of sec. 2002(a)(9) were modified during the period Oct. 1, 1975–Sept. 30, 1978 by sec. 7(a)(3) of P.L. 93–647, as amended (see p. 759), sec. 5 of P.L. 94–401, as amended by sec. 1(b) of P.L. 95–171, added to par. (9)(A)(ii) subclause (IV) (effective Sept. 7, 1976 to Sept. 30, 1978) and subclause (V) (effective Oct. 1, 1975 to Sept. 30, 1978). Under the provisions of P.L. 94–401, as amended, subclauses (IV) and (V) were deleted effective Oct. 1, 1978.

[2] Subpar. (B) was amended by sec. 5 of P.L. 95–59.

[3] Subpar. (D) was added by sec. 1001(a) of P.L. 96–499. Sec. 1001(c) provides:

"(c) The Department of Health and Human Services shall assist each State in conducting a systematic assessment of current practices in day care programs funded under title XX of the Social Security Act. Upon completion of such assessments, but not later than June 1, 1981, the Secretary shall provide a summary report of the results of such assessments to the Congress."

the State makes generally available to its residents without cost and without regard to their income.

(11) No payment may be made under this section with respect to any expenditure for the provision of any service to any individual living in any hospital, skilled nursing facility, or intermediate care facility (including any such hospital or facility for mental diseases

taining standards for such services which are reasonably in accord with recommended standards of national organizations concerned with standards for such services, including standards related to admission policies for facilities providing such services, safety, sanitation, and protection of civil rights;

(H) provides that the State's program for the provision of the services described in section 2002(a)(1) will be in effect in all political subdivisions of the State;

(I) provides for financial participation by the State in the provision of the services described in section 2002(a)(1);

(J) provides that any entity (other than an individual practitioner or a group of practitioners) receiving payments for the provision of health related services complies with the requirements of section 1124, and supplies (within such period as may be specified in regulations by the Secretary or by the State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (i) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (ii) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor; and [1]

(K) provides that the State will bar any specified individual from participation in the program for the period specified by the Secretary when required by him to do so pursuant to section 1128, and provides that no payment may be made under the program with respect to any item or service furnished by such individual during such period.[2]

Notwithstanding clause (C), if on December 1, 1974, the State agency which administered or supervised the administration of the portion of the plan of the State for services to the aged, blind, or disabled approved under title VI of this Act which related to blind individuals was different from the agency which administered or supervised the administration of the rest of that plan, the State agency which administered or supervised the administration of the portion of the plan of the State for services to the aged, blind, or disabled related to blind individuals may be designated to administer or supervise the administration of the portion of the State's program for the provision of the services described in section 2002(a)(1) related to blind individuals

[1] Subpar. (J) was added by sec. (3)(d)(1) of P.L. 95-142.
[2] Subpar. (K) was added by sec. 913(e) of P.L. 96-409.

and a separate State agency may be designated to administer or supervise the administration of the rest of the program; and in such case the part of the program which each agency administers, or the administration of which each agency supervises, shall be regarded as a separate program for the provision of the services described in section 2002(a)(1) for purposes of this title. The date selected by the

State pursuant to section 2004(1) as the beginning of the services program period for each of the separate programs shall be the same.[1]

(2) The Secretary shall approve any plan which complies with the provisions of paragraph (1).

(e)(1) No payment may be made under section 2002 to any State which does not have a plan approved under subsection (d).[2]

(2) In the case of any State plan which has been approved by the Secretary under subsection (d), if the Secretary, after reasonable notice and an opportunity for a hearing to the State, finds—

(A) that the plan no longer complies with the provisions of subsection (d)(1), or

(B) that in the administration of the plan there is a substantial failure to comply with any such provision,

the Secretary shall, except as provided in paragraph (3), notify the State that further payments will not be made to the State under section 2002 until he is satisfied that there will no longer be any such failure to comply, and until he is so satisfied he shall make no further payments to the State.

(3) The Secretary may suspend implementation of any termination of payments under paragraph (2) for such period as he determines appropriate and instead reduce the amount otherwise payable to the State under section 2002 for expenditures during that period by 3 percent for each clause of subsection (d)(1) with respect to which there is a finding of noncompliance and with respect to which he is not yet satisfied that there will no longer be any such failure to comply.

(f) The provisions of section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 shall be applicable to services provided by any State pursuant to this title with respect to individuals suffering from drug addiction or alcoholism.[3]

Services Program Planning

Sec. 2004. A State's services program planning meets the requirements of this section if, for the purpose of assuring public participation in the development of the program for the provision of the services described in section 2002(a)(1) within the State—

(1) for each services program period, the beginning of the fiscal year of the Federal Government, the State government, or the political subdivisions of such State is established as the beginning of the State's services program period, and the end of such

[1] "Services program year" was changed to "services program period" by sec. 206 of P.L. 96–272.

[2] Par. (1) was amended by sec. 6(1) of P.L. 96–473.

[3] Subsec. (f) was added to sec. 2003 by sec. 4 of P.L. 94–120 as amended by sec. 6 of P.L. 94–401, by sec. 1(c) of P.L. 95–171, sec. 5 of P.L. 96–178, and sec. 209 of P.L. 96–272

(D) under a simplified employee pension if, at the time of the payment, it is reasonable to believe that the employee will be entitled to a deduction under section 219 for such payment; [1]

(6) the payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101, or

(B) of any payment required from an employee under a State unemployment compensation law,

with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor; [2]

(7)(A) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business or for domestic service in a private home of the employer;

(B) cash remuneration paid by an employer in any calendar quarter to an employee for domestic service in a private home of the employer, if the cash remuneration paid in such quarter by the employer to the employee for such service is less than $50. As used in this subparagraph, the term "domestic service in a private home of the employer," does not include service described in subsection (g)(5);

(C) cash remuneration paid by an employer in any calendar year to an employee for service not in the course of the employer's trade or business, if the cash remuneration paid in such year by the employer to the employee for such service is less than $100. As used in this subparagraph, the term "service not in the course of the employer's trade or business" does not include

[1] Subpar. (D) was added by sec. 101 of P.L. 96–222.

[2] Par. (6) was amended by sec. 1141(a)(1) of P.L. 96–499, effective as specified in sec. 1141(c) which provides:

"(c) EFFECTIVE DATES.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply with respect to remuneration paid after December 31, 1980.

"(2) EXCEPTION FOR STATE AND LOCAL GOVERNMENTS.—

"(A) the amendments made by this section (insofar as they affect the application of section 218 of the Social Security Act) shall not apply to any payment made before January 1, 1984, by any governmental unit for positions of a kind for which all or a substantial portion of the social security employee taxes were paid by such governmental unit (without deduction from the remuneration of the employee) under the practices of such governmental unit in effect on October 1, 1980.

"(B) For purposes of subparagraph (A), the term 'social security employee taxes' means the amount required to be paid under section 218 of the Social Security Act as the equivalent of the taxes imposed by section 3101 of the Internal Revenue Code of 1954.

"(C) For purposes of subpar. (A), the term 'governmental unit' means a State or political subdivision thereof within the meaning of sec. 218 of the Social Security Act."

domestic service in a private home of the employer and does not include service described in subsection (g)(5);[1]

(8)(A) remuneration paid in any medium other than cash for agricultural labor;

(B) cash remuneration paid by an employer in any calendar year to an employee for agricultural labor unless (i) the cash remuneration paid in such year by the employer to the employee for such labor is $150 or more, or (ii) the employee performs agricultural labor for the employer on 20 days or more during such year for cash remuneration computed on a time basis;

(9) any payment (other than vacation or sick pay) made to an employee after the month in which he attains age 62, if such employee did not work for the employer in the period for which such payment is made;[2]

(10) remuneration paid by an employer in any calendar year to an employee for service described in subsection (d)(3)(C) (relating to home workers), if the cash remuneration paid in such year by the employer to the employee for such service is less than $100;[3]

(11) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remunera-

[1] Subpar. (C) was amended by sec. 356(a) of P.L. 95-216.
[2] Par. (9) was amended by sec. 104(i) of P.L. 92-603 effective with respect to payments after 1974.
[3] Par. (10) was amended by sec. 356(a) of P.L. 95-216.

affect eligibility for, or increase the amount of, such pension, retirement or retired pay, annuity, or similar payment, and

(B) the State law may provide for limitations on the amount of any such a reduction to take into account contributions made by the individual for the pensions, retirement or retired pay, annuity, or other similar periodic payment;[1][2]

(16)(A) wage information contained in the records of the agency administering the State law which is necessary (as determined by the Secretary of Health, Education, and Welfare in regulations) for purposes of determining an individual's eligibility for aid or services, or the amount of such aid or services, under a State plan for aid and services to needy families with children approved under part A of title IV of the Social Security Act, shall be made available to a State or political subdivision thereof when such information is specifically requested by such State or political subdivision for such purposes, and

(B) such safeguards are established as are necessary (as determined by the Secretary of Health, Education, and Welfare in regulations) to insure that such information is used only for the purposes authorized under subparagraph (A);[3]

(17) all the rights, privileges, or immunities conferred by such law or by acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal such law at any time.[3]

(b) NOTIFICATION.—The Secretary of Labor shall, upon approving such law, notify the governor of the State of his approval.

(c) CERTIFICATION.—On October 31 of each taxable year the Secretary of Labor shall certify to the Secretary of the Treasury each State whose law he has previously approved, except that he shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has amended its law so that it no longer contains the provisions specified in subsection (a) or has with respect to the 12-month period ending on such October 31 failed to comply substantially with any such provision in such subsection. No finding of a failure to comply substantially with any provision in paragraph (5) of subsection (a) shall be based on an application or interpretation of State law (1) until all administrative review provided for under the laws of the State has been exhausted, or (2) with respect to which the time for judicial review provided by the laws

[1] Paragraphs (13), (14), and (15) were added (and the former paragraph (13) was redesignated as (16)) by section 314 of P.L. 94-566 effective for certifications starting 1978 (1979 in the case of States whose legislatures have no regular session in 1977).
[2] Paragraph (15) was amended by section 302(e) of P.L. 95-19 and was also amended (effective for certifications for 1981 and later) by sec. 414 of P.L. 96-364.
[3] Paragraph (16) was added (and the former paragraph (16) was redesignated as (17)) by section 403(b) of P.L. 95-216.

of the State has not expired, or (3) with respect to which any judicial review is pending. On October 31 of any taxable year after 1971, the Secretary of Labor shall not certify any State which, after reasonable notice and opportunity for hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by reason of the exactment of the Employment Security Amendments of 1970 to be included therein, or has with respect to the 12-month period ending on such October 31, failed to comply substantially with any such provision. On October 31 of any taxable year after 1977, the Secretary shall not certify any State which, after reasonable notice and opportunity for a hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by reason of the enactment of the Unemployment Compensation Amendments of 1976 to be included therein, or has with respect to the 12-month period ending on such October 31, failed to comply substantially with any such provision.[1]

(d) NOTICE OF NONCERTIFICATION.—If at any time the Secretary of Labor has reason to believe that a State whose law he has previously approved may not be certified under subsection (c), he shall promptly so notify the governor of such State.

[1] Subsec. (c) was amended effective starting with certifications for 1978 by sec. 312 of P.L. 94–566. The first reference to "the Secretary" in the last sentence apparently should refer to "the Secretary of Labor." Sec. 1025 of P.L. 96–499 contains an additional certification requirement as follows:

"SEC. 1025. On October 31 of any taxable year after 1980, the Secretary of Labor shall not certify any State, as provided in section 3304(c) of the Internal Revenue Code of 1954, which, after reasonable notice and opportunity for a hearing to the State agency, the Secretary of Labor finds has failed to amend its law so that it contains each of the provisions required by reason of the enactment of the preceding provisions of this part to be included therein, or has with respect to the 12-month period ending on such October 31, failed to comply substantially with any such provision."

(e) CHANGE OF LAW DURING 12-MONTH PERIOD.—Whenever—

(1) any provision of this section, section 3302, or section 3303 refers to a 12-month period ending on October 31 of a year, and

(2) the law applicable to one portion of such period differs from the law applicable to another portion of such period,

then such provision shall be applied by taking into account for each such portion the law applicable to such portion.

(f) DEFINITION OF INSTITUTION OF HIGHER EDUCATION.—For purposes of subsection (a)(6), the term "institution of higher education" means an educational institution in any State which—

(1) admits as regular students only individuals having a certificate of graduation from a high school, or the recognized equivalent of such a certificate;

(2) is legally authorized within such State to provide a program of education beyond high school;

(3) provides an educational program for it which awards a bachelor's or higher degree, or provides a program which is acceptable for full credit toward such a degree, or offers a program of training to prepare students for gainful employment in a recognized occupation; and

(4) is a public or other nonprofit institution.[1]

SEC. 3305. APPLICABILITY OF STATE LAW[2]

(a) INTERSTATE AND FOREIGN COMMERCE.—No person required under a State law to make payments to an unemployment fund shall be relieved from compliance therewith on the ground that he is engaged in interstate or foreign commerce, or that the State law does not distinguish between employees engaged in interstate or foreign commerce and those engaged in intrastate commerce.

(b) FEDERAL INSTRUMENTALITIES IN GENERAL.—The legislature of any State may require any instrumentality of the United States (other than an instrumentality to which section 3306(c)(6) applies), and the individuals in its employ, to make contributions to an unemployment fund under a State unemployment compensation law approved by the Secretary of Labor under section 3304 and (except as

[1] Subsec. (f) was added by sec. 115(c) of P.L. 94–566.

[2] Sec. 3305 was amended by secs. 1903(a)(15) and 1906(b)(13)(C) of P.L. 94–455.

rate unit of a trade or business of a predecessor, and immediately after the acquisition employs in his trade or business an individual who immediately prior to the acquisition was employed in the trade or business of such predecessor, then, for the purpose of determining whether the successor employer has paid remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment equal to $6,000 to such individual during such calendar year, any remuneration (other than remuneration referred to in the succeeding paragraphs of this subsection) with respect to employment paid (or considered under this paragraph as having been paid) to such individual by such predecessor during such calendar year and prior to such acquisition shall be considered as having been paid by such successor employer; [1]

(2) the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of his dependents under a plan or system established by an employer which makes provision for his employees generally (or for his employees generally and their dependents) or for a class or classes of his employees (or for a class or classes of his employees and their dependents), on account of—

(A) retirement, or

(B) sickness or accident disability, or

(C) medical or hospitalization expenses in connection with sickness or accident disability, or

(D) death;

(3) any payment made to an employee (including any amount paid by an employer for insurance or annuities or into a fund, to provide for any such payment) on account of retirement;

(4) any payment on account of sickness or accident disability, or medical or hospitalization expenses in connection with sickness or accident disability, made by an employer to or on behalf of, an employee after the expiration of 6 calendar months following the last calendar month in which the employee worked for such employer;

(5) any payment made to, or on behalf of, an employee or his beneficiary—

(A) from or to a trust described in section 401(a) which is exempt from tax under section 501(a) at the time of such payment unless such payment is made to an employee of the

[1] Paragraph (1) was amended, effective for wages paid after 1977, by section 211(a) of Public Law 94-566.

trust as remuneration for services rendered as such employee and not as a beneficiary of the trust, or

(B) under or to an annuity plan which, at the time of such payment, is a plan described in section 403(a),

(C) under or to a bond purchase plan which, at the time of such payment, is a qualified bond purchase plan described in section 405(a), or

(D) under a simplified employee pension if, at the time of the payment, it is reasonable to believe that the employee will be entitled to a deduction under section 219 for such payment;[1]

(6) the payment by an employer (without deduction from the remuneration of the employee)—

(A) of the tax imposed upon an employee under section 3101, or

(B) of any payment required from an employee under a State unemployment compensation law, with respect to remuneration paid to an employee for domestic service in a private home of the employer or for agricultural labor;[2]

(7) remuneration paid in any medium other than cash to an employee for service not in the course of the employer's trade or business;

(8) any payment (other than vacation or sick pay) made to an employee after the month in which he attains the age of 65, if he did not work for the employer in the period for which such payment is made;

(9) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of the payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 217;

(10) any payment or series of payments by an employer to an employee or any of his dependents which is paid—

(A) upon or after the termination of an employee's employment relationship because of (i) death, (ii) retirement for disability, or (iii) retirement after attaining an age specified in the plan referred to in subparagraph (B) or in a pension plan of the employer, and

(B) under a plan established by the employer which makes provision for his employees generally or a class or classes of his employees (or for such employees or class or classes of employees and their dependents), other than any such payment or series of payments which would have been paid if

[1] Subpar. (D) was added by sec. 101 of P.L. 96–222.
[2] Par. (6) was amended by sec. 1141(b) of P.L. 96–499.

the employee's employment relationship had not been so terminated;

(11) remuneration for agricultural labor paid in any medium other than cash; or[1]

(12) any contribution, payment, or service, provided by an employer which may be excluded from the gross income of an employee, his spouse, or his dependents, under the provisions of section 120 (relating to amounts received under qualified group legal services plans).[2]

(c) EMPLOYMENT.—For purposes of this chapter, the term "employment" means any service performed prior to 1955, which was employ-

[1] Par. (11) was added by sec. 111(a) of P.L. 94–566.
[2] Par. (12) was added by sec. 3(a) of P.L. 95–472, effective for taxable years beginning after Dec. 31, 1976.

(8) DISCLOSURE OF CERTAIN RETURN INFORMATION BY SOCIAL SECURITY ADMINISTRATION TO STATE AND LOCAL CHILD SUPPORT ENFORCEMENT AGENCIES.—

(A) IN GENERAL.—Upon written request, the Commissioner of Social Security shall disclose directly to officers and employees of a State or local child support enforcement agency return information from returns with respect to net earnings from self-employment (as defined in section 1402), wages (as defined in section 3121(a) or 3401(a)), and payments of retirement income which have been disclosed to the Social Security Administration as provided by paragraph (1) or (5) of this subsection.

(B) RESTRICTION ON DISCLOSURE.—The Commissioner of Social Security shall disclose return information under subparagraph (A) only for purposes of, and to the extent necessary in, establishing and collecting child support obligations from, and locating, individuals owing such obligations. For purposes of the preceding sentence, the term "child support obligations" only includes obligations which are being enforced pursuant to a plan described in section 454 of the Social Security Act which has been approved by the Secretary of Health and Human Services under part D of title IV of such Act.

(C) STATE OR LOCAL CHILD SUPPORT ENFORCEMENT AGENCY.—For purposes of this paragraph, the term "State or local child support enforcement agency" means any agency of a State or political subdivision thereof operating pursuant to a plan described in subparagraph (B).[1]

* * * * * * *

(p) Procedure and Recordkeeping.—

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(3) RECORDS OF INSPECTION AND DISCLOSURE.

(A) System of recordkeeping. Except as otherwise provided by this paragraph, the Secretary shall maintain a permanent system of standardized records or accountings of all requests for inspection or disclosure of returns and return information (including the reasons for and dates of such requests) and of returns and return information inspected or disclosed under this section. Notwithstanding the provisions of section 552a(c) of title 5, United States Code, the Secretary shall not be required to maintain a record or accounting of requests for inspection or disclosure of returns and return information, or of returns and return information inspected or disclosed, under the authority of subsections (c), (e),

[1] Par. (8) was added by sec. 408 of P.L. 96-265 as amended by sec. 11(a)(2) of P.L. 96-611.

(h)(1), (3)(A), or (4), (i)(4) or (6)(A)(ii), (k)(1), (2), or (6), (l)(1), (4)(B), (5), (7), or (8), (m), or (n). The records or accountings required to be maintained under this paragraph shall be available for examination by the Joint Committee on Taxation or the Chief of Staff of such joint committee. Such record or accounting shall also be available for examination by such person or persons as may be, but only to the extent, authorized to make such examination under section 552a(c)(3) of title 5, United States Code.[1]

* * * * * * *

(4) SAFEGUARDS.—Any Federal agency described in subsection (h)(2), (i)(1), (2) or (5), (j)(1) or (2), (l)(1), (2), or (5), or (o)(1), the General Accounting Office, or any agency, body, or commission described in subsection (d) or (l)(3), (6), (7), or (8) shall, as a condition for receiving returns or return information—

(A) establish and maintain, to the satisfaction of the Secretary, a permanent system of standardized records with respect to any request, the reason for such request, and the date of such request made by or of it and any disclosure of return or return information made by or to it;

(B) establish and maintain, to the satisfaction of the Secretary, a secure area or place in which such returns or return information shall be stored;

(C) restrict, to the satisfaction of the Secretary, access to the returns or return information only to persons whose duties or responsibilities require access and to whom disclosure may be made under the provisions of this title;

(D) provide such other safeguards which the Secretary determines (and which he prescribes in regulations) to be necessary or appropriate to protect the confidentiality of the returns or return information;

(E) furnish a report to the Secretary, at such time and containing such information as the Secretary may prescribe, which describes the procedures established and utilized by such agency, body, or commission or the General Accounting Office for ensuring the confidentiality of returns and return information required by this paragraph; and

(F) upon completion of use of such returns or return information—

(i) in the case of an agency, body, or commission described in subsection (d) or (l)(6), (7), or (8), return to the Secretary such returns or return information (along with any copies made therefrom) or make such returns or return information undisclosable in any manner and furnish a written report to the Secretary describing such manner; and

(ii) in the case of an agency described in subsections (h)(2), (i)(1), (2), or (5), (j)(1) or (2), (l)(1), (2), or (5), or (o)(1), the commission described in subsection (l)(3), or the General Accounting Office, either—

(I) return to the Secretary such returns or return information (along with any copies made therefrom),

(II) otherwise make such returns or return information undisclosable, or

(III) to the extent not so returned or made undisclosable, ensure that the conditions of subparagraphs (A), (B), (C), (D), and (E) of this paragraph continue to be met with respect to such returns or return information.

except that the conditions of subparagraphs (A), (B), (C), (D), and (E) shall cease to apply with respect to any return or return information if, and to the extent that, such return or return information is disclosed in the course of any judicial or administrative proceeding and made a part of the public record thereof. If the Secretary determines that any such agency, body, or commission or the General Accounting Office has failed to, or does not, meet the requirements of this paragraph, he may, after any proceedings for review established under paragraph (7), take such actions as are necessary to ensure such requirements are met, including refusing to disclose returns or return information to such agency, body, or commission or the General Accounting Office until he determines that such requirements have been or will be met.[1]

* * * * * * *

[1] Par. (3) was amended by sec. 127 of P.L. 96–249 and by sec. 408 of P.L. 96–265 as amended by sec. 11(a)(2)(B)(i) of P.L. 96–611.

[1] Par. (4) was amended by sec. 127 of P.L. 96–249 and by sec. 408 of P.L. 96–265 as amended by sec. 11(a)(2)(B) of P.L. 96–611.

SEC. 6109. IDENTIFYING NUMBERS.

(a) SUPPLYING OF IDENTIFYING NUMBER.—When required by regulations prescribed by the Secretary:

(1) INCLUSION IN RETURNS.—Any person required under the authority of this title to make a return, statement, or other document shall include in such return, statement, or other document such identifying number as may be prescribed for securing proper identification of such person.

(2) FURNISHING NUMBER TO OTHER PERSONS.—Any person with respect to whom a return, statement, or other document is required under the authority of this title to be made by another person shall furnish to such other person such identifying number as may be prescribed for securing his proper identification.

(3) FURNISHING NUMBER OF ANOTHER PERSON.—Any person required under the authority of this title to make a return, statement, or other document with respect to another person shall request from such other person, and shall include in any such return, statement, or other document, such identifying number as may be prescribed for securing proper identification of such other person.

(4) FURNISHING IDENTIFYING NUMBER OF INCOME TAX RETURN PREPARER.—Any return or claim for refund prepared by an income tax return preparer shall bear such identifying number for securing proper identification of such preparer, his employer, or both, as may be prescribed. For purposes of this paragraph, the terms "return" and "claim for refund" have the respective meanings given to such terms by section 6696(e).

For purposes of this subsection, the identifying number of an individual (or his estate) shall be such individual's social security account number.

(b) LIMITATION.—

(1) Except as provided in paragraph (2), a return of any person with respect to his liability for tax, or any statement or other document in support thereof, shall not be considered for purposes of paragraphs (2) and (3) of subsection (a) as a return, statement, or other document with respect to another person.

(2) For purposes of paragraphs (2) and (3) of subsection (a), a return of an estate or trust with respect to its liability for tax, and any statement or other document in support thereof, shall be considered as a return, statement, or other document with respect to each beneficiary of such estate or trust.

(c) REQUIREMENT OF INFORMATION.—For purposes of this section, the Secretary is authorized to require such information as may be necessary to assign an identifying number to any person.

made under the penalties of perjury, and which he does not believe to be true and correct as to every material matter; or

(2) AID OR ASSISTANCE.—Willfully aids or assists in, or procures, counsels, or advises the preparation or presentation under, or in connection with any matter arising under, the internal revenue laws, of a return, affidavit, claim, or other document, which is fraudulent or is false as to any material matter, whether or not such falsity or fraud is with the knowledge or consent of the person authorized or required to present such return, affidavit, claim, or document;

* * * * * * *

shall be guilty of a felony and, upon conviction thereof, shall be fined not more than $5,000, or imprisoned not more than 3 years; or both, together with the costs of prosecution.

SEC. 7207. FRAUDULENT RETURNS, STATEMENTS, OR OTHER DOCUMENTS.

Any person who willfully delivers or discloses to the Secretary or his delegate any list, return, account, statement, or other document, known by him to be fraudulent or to be false as to any material matter, shall be fined not more than $1,000, or imprisoned not more than 1 year, or both. Any person required pursuant to sections 6047 (b) or (c), 6056 or 6104(d) to furnish any information to the Secretary or any other person who willfully furnishes to the Secretary or such other person any information known by him to be fraudulent or to be false as to any material matter shall be fined not more than $1,000, or imprisoned not more than 1 year, or both.

* * * * * * *

SEC. 7213. UNAUTHORIZED DISCLOSURE OF INFORMATION.

(a) RETURNS AND RETURN INFORMATION.—

(1) FEDERAL EMPLOYEES AND OTHER PERSONS.—It shall be unlawful for any officer or employee of the United States or any person described in section 6103(n) (or an officer or employee of any such person), or any former officer or employee, willfully to disclose to any person, except as authorized in this title, any return or return information (as defined in section 6103(b)). Any violation of this paragraph shall be a felony punishable upon conviction by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution, and if such offense is committed by any officer or employee of the United States, he shall, in addition to any other punishment, be dismissed from office or discharged from employment upon conviction of such offense.

(2) STATE AND OTHER EMPLOYEES.—It shall be unlawful for any person (not described in paragraph (1)) willfully to disclose to any person, except as authorized in this title, any return or return information (as defined in section 6103(b)) acquired by him or another person under subsection (d), (l)(6), (7), or (8), or (m)(4) of section 6103. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.[1]

(3) OTHER PERSONS.—It shall be unlawful for any person to whom any return or return information (as defined in section 6103(b)) is disclosed in a manner unauthorized by this title thereafter willfully to print or publish in any manner not provided by law any such return or return information. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.

(4) SOLICITATION.—It shall be unlawful for any person willfully to offer any item of material value in exchange for any return or return information (as defined in section 6103(b)) and to receive as a result of such solicitation any such return or return information. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.

(5) SHAREHOLDERS.—It shall be unlawful for any person to whom a return or return information (as defined in section 6103(b)) is disclosed pursuant to the provisions of section 6103(e)(1)(D)(iii) willfully to disclose such return or return information in any manner not provided by law. Any violation of this paragraph shall be a felony punishable by a fine in any amount not to exceed $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution.

(b) DISCLOSURE OF OPERATIONS OF MANUFACTURER OR PRODUCER.—Any officer or employee of the United States who divulges or makes known in any manner whatever not provided by law to any person the operations, style of work, or apparatus of any manufacturer or producer visited by him in the discharge of his official duties shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $1,000, or imprisoned not more than 1 year, or both, together with the costs of prosecution; and the offender shall be dismissed from office or discharged from employment.

[1] Par. (2) was amended by sec. 127 of P.L. 92–249, sec. 408 of P.L. 96–265, sec. 302 of P.L. 96–499, and sec. 11 of P.L. 96–611.

Federal-State Extended Unemployment Compensation Act, As Amended

Excerpt From Public Law 91–373, August 10, 1970

* * * * * * *

Title II—Federal-State Extended Unemployment Compensation Program

Short Title

Sec. 201. This title may be cited as the "Federal-State Extended Unemployment Compensation Act of 1970".

Payment of Extended Compensation

State Law Requirements

Sec. 202. (a)(1) For purposes of section 3304(a)(11) of the Internal Revenue Code of 1954, a State law shall provide that payment of extended compensation shall be made, for any week of unemployment which begins in the individual's eligibility period, to individuals who have exhausted all rights to regular compensation under the State law and who have no rights to regular compensation with respect to such week under such law or any other State unemployment compensation law or to compensation under any other Federal law and are not receiving compensation with respect to such week under the unemployment compensation law of Canada. For purposes of the preceding sentence, an individual shall have exhausted his rights to regular compensation under a State law (A) when no payments of regular compensation can be made under such law because such individual has received all regular compensation available to him based on employment or wages during his base period, or (B) when his rights to such compensation have terminated by reason of the expiration of the benefit year with respect to which such rights existed.[1]

(2) Except where inconsistent with the provisions of this title, the terms and conditions of the State law which apply to claims for regular compensation and to the payment thereof shall apply to claims for extended compensation and to the payment thereof.

[1] Paragraph (1) was amended by section 118(d)(1) of P.L. 94–566.

(3) (A) Notwithstanding the provisions of paragraph (2), payment of extended compensation under this Act shall not be made to any individual for any week of unemployment in his eligibility period—

(i) during which he fails to accept any offer of suitable work (as defined in subparagraph (c)) or fails to apply for any suitable work to which he was referred by the State agency; or

(ii) during which he fails to actively engage in seeking work.

(B) If any individual is ineligible for extended compensation for any week by reason of a failure described in clause (i) or (ii) of subparagraph (A), the individual shall be ineligible to receive extended compensation for any week which begins during a period which—

(i) begins with the week following the week in which such failure occurs, and

(ii) does not end until such individual has been employed during at least 4 weeks which begin after such failure and the total of the remuneration earned by the individual for being so employed is not less than the product of 4 multiplied by the individual's average weekly benefit amount (as determined for purposes of subsection (b) (1) (c)) for his benefit year.

(C) For purposes of this paragraph, the term "suitable work" means, with respect to any individual, any work which is within such individual's capabilities; except that, if the individual furnishes evidence satisfactory to the State agency that such individual's prospects for obtaining work in his customary occupation within a reasonably short period are good, the determination of whether any work is suitable work with respect to such individual shall be made in accordance with the applicable State law.

(D) Extended compensation shall not be denied under clause (i) of subparagraph (A) to any individual for any week by reason of a failure to accept an offer of, or apply for, suitable work—

(i) if the gross average weekly remuneration payable to such individual for the position does not exceed the sum of—

(I) the individual's average weekly benefit amount (as determined for purposes of subsection (b) (1) (C)) for his benefit year, plus

(II) the amount (if any) of supplemental unemployment compensation benefits (as defined in section 501(c) (17) (D) of the Internal Revenue Code of 1954) payable to such individual for such week;

(ii) if the position was not offered to such individual in writing and was not listed with the State employment service;

(iii) if such failure would not result in a denial of compensation under the provisions of the applicable State law to the extent that such provisions are not inconsistent with the provisions of subparagraphs (C) and (E); or

(iv) if the position pays wages less than the higher of—

(I) the minimum wage provided by section 6(a) (1) of the Fair Labor Standards Act of 1938, without regard to any exemption; or

(II) any applicable State or local minimum wage.

(E) For purposes of this paragraph, an individual shall be treated as actively engaged in seeking work during any week if—

(i) the individual has engaged in a systematic and sustained effort to obtain work during such week, and

(ii) the individual provides tangible evidence to the State agency that he has engaged in such an effort during such week.

(F) For purposes of section 3304(a) (11) of the Internal Revenue Code of 1954, a State law shall provide for referring applicants for benefits under this Act to any suitable work to which clauses (i), (ii), (iii), and (iv) of subparagraph (D) would not apply.[1]

(4) No provision of State law which terminates a disqualification for voluntarily leaving employment, being discharged for misconduct, or refusing suitable employment shall apply for purposes of determining eligibility for extended compensation unless such termination is based upon employment subsequent to the date of such disqualification.[1]

(5) No payment shall be made under this Act to any State in respect of any sharable regular compensation paid to any individual for any week if, under the rules of paragraphs (3) and (4), extended compensation would not have been payable to such individual for such week.[1]

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[1] Pars. (3), (4), and (5) were added with respect to weeks of unemployment beginning after Mar. 31, 1981 by sec. 1024 of P.L. 96–499.

Individuals' Compensation Accounts

(b) (1) The State law shall provide that the State will establish, for each eligible individual who files an application therefor, an extended compensation account with respect to such individual's benefit year. The amount established in such account shall be not less than whichever of the following is the least:

(A) 50 per centum of the total amount of regular compensation (including dependents' allowances) payable to him during such benefit year under such law.

(B) thirteen times his average weekly benefit amount, or

(C) thirty-nine times his average weekly benefit amount, reduced by the regular compensation paid (or deemed paid) to him during such benefit year under such law;

except that the amount so determined shall (if the State law so provides) be reduced by the aggregate amount of additional compensation paid (or deemed paid) to him under such law for prior weeks of unemployment in such benefit year which did not begin in an extended benefit period.

(2) For purposes of paragraph (1), an individual's weekly benefit amount for a week is the amount of regular compensation (including dependents' allowances) under the State law payable to such individual for such week for total unemployment.

Cessation of Extended Benefits When Paid Under an Interstate Claim in a State Where Extended Benefit Period Is Not in Effect

(c) (1) Except as provided in paragraph (2), payment of extended compensation shall not be made to any individual for any week if—

(A) extended compensation would (but for this subsection) have been payable for such week pursuant to an interstate claim filed in any State under the interstate benefit payment plan, and

(B) an extended benefit period is not in effect for such week in such State.

(2) Paragraph (1) shall not apply with respect to the first 2 weeks for which extended compensation is payable (determined without regard to this subsection) pursuant to an interstate claim filed under the interstate benefit payment plan to the individual from the extended compensation account established for the benefit year.

(3) Section 3304(a) (9) (A) of the Internal Revenue Code of 1954

(B) no extended benefit period may begin by reason of a State "on" indicator before the fourteenth week after the close of a prior extended benefit period with respect to such State.

(2) When a determination has been made that an extended benefit period is beginning or ending with respect to a State (or all the States), the Secretary shall cause notice of such determination to be published in the Federal Register.

Eligibility Period

(c) For purposes of this title, an individual's eligibility period under the State law shall consist of the weeks in his benefit year which begin in an extended benefit period and, if his benefit year ends within such extended benefit period, any weeks thereafter which begin in such extended benefit period.

National "On" and "Off" Indicators

(d) For purposes of this section—

(1) There is a national "on" indicator for a week if, for the period consisting of such week and the immediately preceding twelve weeks, the rate of insured unemployment (seasonally adjusted) for all States equaled or exceeded 4.5 per centum (determined by reference to the average monthly covered employment for the first four of the most recent six calendar quarters ending before the close of such period).

(2) There is a national "off" indicator for a week if, for the period consisting of such week and the immediately preceding twelve weeks, the rate of insured unemployment (seasonally adjusted) for all States was less than 4.5 per centum (determined by reference to the average monthly covered employment for the first four of the most recent six calendar quarters ending before the close of such period).[1]

State "On" and "Off" Indicators

(e) For purposes of this section—

(1) There is a State "on" indicator for a week if the rate of insured unemployment under the State law for the period consisting of such week and the immediately preceding twelve weeks—

[1] Subsection (d) was amended by section 311(a) of P.L. 94-566 effective for weeks beginning after December 31, 1976. Prior to this effective date, subsection (d) includes the following sentence: Effective with respect to compensation for weeks of unemployment beginning before December 31, 1976, and beginning after December 31, 1974 (or, if later, the date established pursuant to State law), the State may by law provide that the determination of whether there has been a national "on" or "off" indicator beginning or ending any extended benefit period shall be made under this subsection as if the phrase "4.5 per centum," contained in paragraphs (1) and (2), read "4 per centum."

(A) equaled or exceeded 120 per centum of the average of such rates for the corresponding thirteen-week period ending in each of the preceding two calendar years, and

(B) equaled or exceeded 4 per centum.

(2) There is a State "off" indicator for a week if, for the period consisting of such week and the immediately preceding twelve weeks, either subparagraph (A) or subparagraph (B) of paragraph (1) is not satisfied.

Effective with respect to compensation for weeks of unemployment beginning after March 30, 1977 (or, if later, the date established pursuant to State law) the State may by law provide that the determination of whether there has been a State "on" or "off" indicator beginning or ending any extended benefit period shall be made under this subsection as if (i) paragraph (1) did not contain subparagraph (A) thereof, and (ii) the figure "4" contained in subparagraph (B) thereof were "5"; except that, notwithstanding any such provision of State law, any week for which there would otherwise be a State "on" indicator shall continue to be such a week and shall not be determined to be a week for which there is a State "off" indicator. For purposes of this subsection, the rate of insured unemployment for any thirteen-week period shall be determined by reference to the average monthly covered employment under the State law for the first four of the most recent six calendar quarters ending before the close of such period.[1]

Rate of Insured Unemployment; Covered Employment

(f)(1) For purposes of subsections (d) and (e), the term "rate of insured unemployment" means the percentage arrived at by dividing—

(A) the average weekly number of individuals filing claims for weeks of unemployment with respect to the specified period, as determined on the basis of the reports made by all State agencies (or, in the case of subsection (e), by the State agency) to the Secretary, by

(B) the average monthly covered employment for the specified period.

(2) Determinations under subsection (d) shall be made by the Secretary in accordance with regulations prescribed by him.

[1] Par. (2) was amended by P.L. 94-45. Effective for weeks beginning after Mar. 30, 1977, par. (2) was further amended by sec. 311(b) of P.L. 94-566. Prior to that effective date,, par. (2) contains the following sentence: "Effective with respect to compensation for weeks of unemployment beginning before Mar. 31, 1977, and beginning after Dec. 31, 1973 (or, if later, the date established pursuant to State law), the State may by law provide that the determination of whether there has been a State 'on' or 'off' indicator beginning or ending any extended benefit period shall be made under this subsection as if par. (1) did not contain subpar. (A) thereof."

(3) Determinations under subsection (e) shall be made by the State agency in accordance with regulations prescribed by the Secretary.

Payments to States

Amount Payable

Sec. 204. (a)(1) There shall be paid to each State an amount equal to one-half of the sum of—

(A) the sharable extended compensation, and

(B) the sharable regular compensation,

paid to individuals under the State law.

(2) No payment shall be made to any State under this subsection in respect to compensation (A) for which the State is entitled to reimbursement under the provisions of any Federal law other than this Act, or (B) paid for the first week in an individual's eligibility period for which extended compensation or sharable regular compensation is paid, if the State law of such State provides for payment (at any time or under any circumstances) of regular compensation to an individual for his first week of otherwise compensable unemployment.[1]

(3) In the case of compensation which is sharable extended compensation or sharable regular compensation by reason of the provision contained in the last sentence of section 203(d), the first paragraph of this subsection shall be applied as if the words "one-half of" read "100 per centum of" but only with respect to compensation that would not have been payable if the State law's provisions as to the State "on" and "off" indicators omitted the 120 percent factor as provided for by Public Law 93-368 and by section 106 of this Act.[2]

(4) The amount which, but for this paragraph, would be payable under this subsection to any State in respect of any compensation paid to an individual whose base period wages include wages for services to which section 3306(c)(7) of the Internal Revenue Code of 1954 applies shall be reduced by an amount which bears the same ratio to the amount which, but for this paragraph, would be payable under this subsection to such State in respect of such compensation as the amount of the base period wages attributable to such services bears to the total amount of the base period wages.[3]

[1] Par. (2) was amended by sec. 1022(a) of P.L. 96-499. See sec. 1022(b), in excerpts from P.L. 96-499, for deferred effective date in certain States.

[2] The reference to "section 106 of this Act" is apparently intended as a reference to sec. 106 of P.L. 93-572 which added par. (3) to this section.

[3] Par. (4) was added by sec. 212 of P.L. 94-566, effective for compensation for weeks of unemployment beginning after Dec. 31, 1978.

Shareable Extended Compensation

(b) For purposes of subsection (a)(1)(A), extended compensation paid to an individual for weeks of unemployment in such individual's eligibility period is sharable extended compensation to the extent that the aggregate extended compensation paid to such individual with respect to any benefit year does not exceed the smallest of the amounts referred to in subparagraphs (A), (B), and (C) of section 202(b)(1).

Shareable Regular Compensation

(c) For purposes of subsection (a)(1)(B), regular compensation paid to an individual for a week of unemployment is sharable regular compensation—

(1) if such week is in such individual's eligibility period (determined under section 203(c)), and

(2) to the extent that the sum of such compensation, plus the regular compensation paid (or deemed paid) to him with respect to prior weeks of unemployment in the benefit year, exceeds twenty-six times (and does not exceed thirty-nine times) the average weekly benefit amount (including allowances for dependents) for weeks of total unemployment payable to such individual under the State law in such benefit year.

Payment on Calendar Month Basis

(d) There shall be paid to each State either in advance or by way of reimbursement, as may be determined by the Secretary, such sum as the Secretary estimates the State will be entitled to receive under this title for each calendar month, reduced or increased, as the case may be, by any sum by which the Secretary finds that his estimates for any prior calendar month were greater or less than the amounts which should have been paid to the State. Such estimates may be made upon the basis of such statistical, sampling, or other method as may be agreed upon by the Secretary and the State agency.

Certification

(e) The Secretary shall from time to time certify to the Secretary of the Treasury for payment to each State the sums payable to such State under this section. The Secretary of the Treasury, prior to audit or settlement by the General Accounting Office, shall make payment to the State in accordance with such certification, by transfers from the extended unemployment compensation account to the account of such State in the Unemployment Trust Fund.

§ 8509. Federal Employees Compensation Account [1]

(a) The Federal Employees Compensation Account (as established by section 909 of the Social Security Act, and hereafter in this section referred to as the 'Account') in the Unemployment Trust Fund (as established by section 904 of such Act) shall consist of—

(1) funds appropriated to or transferred thereto, and

(2) amounts deposited therein pursuant to subsection (c).

(b) Moneys in the Account shall be available only for the purpose of making payments to States pursuant to agreements entered into under this subchapter and making payments of compensation under this subchapter in States which do not have in effect such an agreement.

(c)(1) Each employing agency shall deposit into the Account amounts equal to the expenditures incurred under this subchapter on account of Federal service performed by employees and former employees of that agency.

(2) Deposits required by paragraph (1) shall be made during each calendar quarter and the amount of the deposit to be made by any employing agency during any quarter shall be based on a determination by the Secretary of Labor as to the amounts of payments, made prior to such quarter from the Account based on Federal service performed by employees of such agency after December 31, 1980, with respect to which deposit has not previously been made. The amount to be deposited by any employing agency during any calendar quarter shall be adjusted to take account of any overpayment or underpayment of deposit during any previous quarter for which adjustment has not already been made.

(d) The Secretary of Labor shall certify to the Secretary of the Treasury the amount of the deposit which each employing agency is required to make to the Account during any calendar quarter, and the Secretary of the Treasury shall notify the Secretary of Labor as to the date and amount of any deposit made to such Account by any such agency.

(e) Prior to the beginning of each fiscal year (commencing with the fiscal year which begins October 1, 1981) the Secretary of Labor shall estimate—

(1) the amount of expenditures which will be made from the Account during such year, and

(2) the amount of funds which will be available during such year for the making of such expenditures,

and if, on the basis of such estimate, he determines that the amount described in paragraph (2) is in excess of the amount necessary—

(3) to meet the expenditures described in paragraph (1), and

[1] Sec. 8509 was added by sec. 1023(b) of P.L. 96–499. See also sec. 1023(c) in excerpts from P.L. 96–499.

(4) to provide a reasonable contingency fund so as to assure that there will, during all times in such year, be sufficient sums available in the Account to meet the expenditures described in paragraph (1),

he shall certify the amount of such excess to the Secretary of the Treasury and the Secretary of the Treasury shall transfer, from the Account to the general fund of the Treasury, an amount equal to such excess.

(f) The Secretary of Labor is authorized to establish such rules and regulations as may be necessary or appropriate to carry out the provisions of this section.

(g) Any funds appropriated after the establishment of the Account, for the making of payments for which expenditures are authorized to be made from moneys in the Account, shall be made to the Account; and there are hereby authorized to be appropriated to the Account, from time to time, such sums as may be necessary to assure that there will, at all times, be sufficient sums available in the Account to meet the expenditures authorized to be made from moneys therein.

implementing the provisions of section 1861(v)(5) of the Social Security Act".

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Modification of Provisions Establishing Supplemental Security Income Program

Sec. 19. (a) Section 303(c) of the Social Security Amendments of 1972 is amended to read as follows:

"(c) Section 9 of the Act of April 19, 1950 (64 Stat. 47) is amended to read as follows:

"'SEC. 9. Beginning with the quarter commencing July 1, 1950, the Secretary of the Treasury shall pay quarterly to each State (from sums made available for making payments to the States under section 403(a) of the Social Security Act) an amount, in addition to the amount prescribed to be paid to such State under such section, equal to 80 per centum of the total amount of contributions by the State toward expenditures during the preceding quarter by the State, under the State plan approved under the Social Security Act for aid to dependent children to Navajo and Hopi Indians residing within the boundaries of the State on reservations or on allotted or trust lands, with respect to whom payments are made to the State by the United States under section 403(a) of the Social Security Act, not counting so much of such expenditure to any individual for any month as exceeds the limitations prescribed in such section.'."

(b) Notwithstanding the provisions of section 301 of the Social Security Amendments of 1972, the Secretary of Health, Education, and Welfare shall make payments to the 50 States and the District of Columbia after December 31, 1973, in accordance with the provisions of the Social Security Act as in effect prior to January 1, 1974, for (1) activities carried out through the close of December 31, 1973, under State plans approved under title I, X, XIV, or XVI, of such Act, and (2) administrative activities carried out after December 31, 1973, which such Secretary determines are necessary to bring to a close activities carried out under such State plans.

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Excerpt From Public Law 93–368

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Sec. 8. Section 249B of the Social Security Amendments of 1972 is amended by striking out "June 30, 1974" and inserting in lieu thereof "June 30, 1977".

* * * * * * *

Excerpt From Public Law 93-480

Sec. 4(a) * * *

(b) The Civil Service Commission and the Secretary of Health, Education, and Welfare shall submit to the Committee on Post Office and Civil Service and the Committee on Ways and Means of the House of Representatives, and to the Committee on Post Office and Civil Service and the Committee on Finance of the Senate, on or before March 1, 1975, a report on the steps which have been taken, and the steps which are planned, to enable the Secretary of Health, Education, and Welfare to make the determination and certification referred to in section 1862(c) of the Social Security Act. If such report is not submitted to such committees on or before March 1, 1975, the date specified in such section (as amended by this section) shall be deemed to be July 1, 1975, rather than January 1, 1976.

Excerpts From the Social Services Amendments of 1974

Public Law 93-647, as Amended

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Sec. 3(a) * * *

* * * * * * *

(f) Any child day care service provided under any plan of a State approved under part A, or developed under part B, of title IV of the Social Security Act must meet the requirements applicable, under subsection (a)(9) of section 2002 of the Social Security Act, as amended by this Act, to child day care services with respect to which payment is made under that section. The requirements imposed by this subsection are in lieu of any requirements that would otherwise be applicable under section 522(d) of the Economic Opportunity Act of 1964 to child day care services provided under any plan of a State approved under part A, or developed under part B, of title IV of the Social Security Act.[1]

(g) Section 12(a) of Public Law 93-233 is amended by striking out "January 1, 1975" and inserting "October 1, 1975" in lieu thereof. Notwithstanding the provisions of section 12(a) of Public Law 93-233, the Secretary may make any modification in any regulation described in that section if the modification is necessary to implement the provisions of this part.

* * * * * * *

[1] Sec. 1001(b) of P.L. 96-499 provides:

"(b) The provisions of section 3(f) of P.L. 93-647 shall not apply with respect to child day care services provided after June 30, 1980, and prior to July 1, 1981, which meet applicable standards of State and local laws."

(2) In the case of claims filed prior to the date of enactment of this Act on account of expenditures described in section 1132 of the Social Security Act made in calendar quarters commencing prior to October 1, 1979, there shall be no time limit for the payment of such claims.

(3) In the case of such expenditures made in calendar quarters commencing prior to October 1, 1979, for which no claim has been filed on or before the date of enactment of this Act, payment shall not be made under this Act on account of any such expenditure unless claim therefor is filed (in such form and manner as the Secretary shall by regulation prescribe) prior to January 1, 1981.

(4) The provisions of this subsection shall not be applied so as to deny payment with respect to any expenditure involving adjustments to prior year costs or court-ordered retroactive payments or audit exceptions. The Secretary may waive the requirements of paragraph (3) in the same manner as under section 1132(b) of the Social Security Act.

(c) Notwithstanding any other provision of law, there shall be no time limit for the filing or payment of such claims except as provided in this section, unless such other provision of law, in imposing such a time limitation, specifically exempts such filing or payment from the provisions of this section.

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POSTPONEMENT OF IMPOSITION OF CERTAIN PENALTIES RELATING TO CHILD SUPPORT REQUIREMENTS

SEC. 309. No reduction in the amount payable to any State under title IV of the Social Security Act with respect to any of the fiscal years 1977 through 1980 shall be made prior to October 1, 1981, on account of the provisions of section 403(h) of such Act.[1]

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN RECIPIENTS OF VETERANS' ADMINISTRATION PENSIONS

SEC. 310. (a)(1) Part A of title XI of the Social Security Act is amended by adding after section 1132 (as added by section 305 of this Act) the following new section:

"APPLICANTS OR RECIPIENTS UNDER PUBLIC ASSISTANCE PROGRAMS NOT TO BE REQUIRED TO MAKE ELECTION RESPECTING CERTAIN VETERANS' BENEFITS

"SEC. 1133. (a) Notwithstanding any other provision of law (but subject to subsection (b)), no individual who is an applicant for or recipient of aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV, or of benefits under the Supplemental Security Income program established by title XVI shall—

[1] Sec. 309 was amended by sec. 11(b)(1) of P.L. 96-611.

"(1) be required, as a condition of eligibility for (or of continuing to receive) such aid, assistance, or benefits, to make an election under section 306 of the Veterans' and Survivors' Pension Improvement Act of 1978 with respect to pension paid by the Veterans' Administration, or

"(2) by reason of failure or refusal to make such an election, be denied (or suffer a reduction in the amount of) such aid, assistance, or benefits.

"(b) The provisions of subsection (a) shall be applicable only with respect to an individual, who is an applicant for or recipient of aid, assistance, or benefits described in subsection (a), during a period with respect to which there is in effect—

"(1) in case such individual is an applicant for or recipient of aid or assistance under a State plan referred to in subsection (a), in the State having such plan, or

"(2) in case such individal is an applicant for or recipient of benefits under the Supplemental Security Income program established by title XVI, in the State in which the individual applies for or receives such benefits,

a State plan for medical assistance, approved under title XIX, under which medical assistance is available to such individual only for periods for which such individual is a recipient of aid, assistance, or benefits described in subsection (a).".

(2) The amendment made by paragraph (1) shall be effective on and after January 1, 1979; except that nothing contained in such amendment shall be construed to authorize or require any payment (or increase in payment) of any aid or assistance or benefits referred to in section 1133(a) of the Social Security Act (as added by paragraph (1)) for any benefit period which begins prior to the date of enactment of this Act.

(b)(1)(A) For purposes of section 1902(a)(10)(A) of the Social Security Act, any individual who, prior to the date of enactment of this Act and for the month of December 1978, was eligible for and received aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV of such Act, or was eligible for and received supplemental security income benefits under title XVI of such Act (or a supplementary payment described in section 13(c) of Public Law 93-233), and was also in receipt of (or was a dependent, for purposes of chapter 15 of title 38, United States Code, as in effect on December 31, 1978, of an individual in receipt of) pension from the Veterans' Administration for the month of December 1978 shall (subject to subparagraph (B)) be deemed to have been receiving such aid, assistance, supplemental security income, or supplementary payment, for each calendar month thereafter (prior to the month in which the provisions of this subparagraph cease to be effective with respect

Excerpts from Public Law 96-499

Short Title

SECTION 101. This Act may be cited as the "Omnibus Reconciliation Act of 1980".

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TITLE IX—MEDICARE AND MEDICAID RELATED PROVISIONS

Short Title; Table of Contents of Title

SEC. 900. This title may be cited as the "Medicare and Medicaid Amendments of 1980".

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SEC. 903. (a) * * *.

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(c) Notwithstanding any other provision of law, the Secretary of Health and Human Services (hereinafter in this title referred to as the "Secretary") may not provide for more than a total of six Statewide medicare hospital reimbursement demonstration projects under the authority of section 402 of the Social Security Amendments of 1967 or of section 222 of the Social Security Amendments of 1972, including any such projects provided for before the date of the enactment of this Act.

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SEC. 904. (a) * * *.

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(c) Within three years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Congress a report evaluating the programs established by the amendments made by this section and shall include in such report an analysis of—

(1) the extent and effect of the agreements under such programs on availability and effective and economical provision of long-term care services,

(2) whether such programs should be continued,

(3) the results of any demonstration projects conducted under such programs, and

(4) whether eligibility to participate in such programs should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

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SEC. 914(a) * * *.

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(b)(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

* * * * * * *

(d) The Secretary shall report to the Congress, not later than December 31, 1981, on actions the Secretary has taken (1) to coordinate the conduct of institutional audits and inspections which are required under the programs funded under title V, XVIII, or XIX of the Social Security Act, and (2) to coordinate such audits and inspections

with those conducted by other cost payers, and he shall include in such report recommendations for such legislation as he deems appropriate to assure the maximum feasible coordination of such institutional audits and inspections.

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SEC. 918(a) * * *.

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(b)(2)(A) The amendments made by paragraph (1) shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

Study of Need for Dual Participation of Skilled Nursing Facilities

SEC. 919. (a)(1) The Secretary of Health and Human Services shall conduct a study of the availability and need for skilled nursing facility services covered under part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act.

(2) Such study shall include—

(A) an investigation of the desirability and feasibility of imposing a requirement that skilled nursing facilities (i) which furnish services to patients covered under State plans approved under title XIX of the Social Security Act also furnish such services to patients covered under part A of title XVIII of such Act, and (ii) which furnish services to patients covered under such title XVIII also furnish such services to patients covered under such State plans,

(B) an evaluation of the impact of existing laws and regulations on skilled nursing facilities and individuals covered under such State plans and under part A of such title XVIII, and an evaluation of the extent to which existing laws and regulations encourage skilled nursing facilities to accept only title XVIII beneficiaries or title XIX recipients, and

(C) an investigation of possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing facility services.

(3) In developing such study, the Secretary shall consult with professional organizations, health experts, private insurers, nursing home providers, and consumers of skilled nursing facility services.

(b) Within one year after the date of the enactment of this Act, the Secretary shall complete such study and shall submit to the Congress a full and complete report thereon, together with recommendations with respect to the matters covered by such study (including any recommendations for administrative or legislative changes).

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Response of Professional Standards Review Organizations to Freedom of Information Act Requests

SEC. 928. No Professional Standards Review Organization designated (conditionally or otherwise) under part B of title XI of the Social Security Act shall be required to make available any records pursuant to a request made under section 552 of title 5, United States Code, until the later of (1) one year after the date of entry of a final court order requiring that such records be made available, or (2) the last date of the Congress during which the court order was entered.

Study of Professional Standards Review Organizations Norms, Standards, and Criteria

SEC. 929. The Secretary of Health and Human Services shall, in consultation with the National Professional Standards Review Council, conduct a nationwide study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country. The study shall include an assessment of the rationale that contributes to these regional differences. The Secretary shall report the findings and conclusions made with respect to the study to the Congress within one year after the date of the enactment of this Act.

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SEC. 947. (a) * * *

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(e) The coverage period under part B of title XVIII of the Social Security Act of an individual whose coverage period attributable to a State agreement under section 1843 of such Act is terminated and who has filed notice before the end of the third calendar month beginning after the date of the enactment of this Act that he no longer wishes to participate in the insurance program established by part B of title XVIII shall terminate on the earlier of (1) the day specified in section 1838 without the amendments made by this section, or (2) (unless the individual files notice before the day specified in this clause that he wishes his coverage period to terminate as provided in clause (1)) the day on which his coverage period would terminate if the individual filed notice in the fourth calendar month beginning after the date of the enactment of this Act.

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Studies and Demonstration Projects

SEC. 958. (a) The Secretary of Health and Human Services shall develop and carry out a demonstration project to determine (1) the extent to which the commencement of nutritional therapy in early renal failure, utilizing (but not limited to) controlled protein substances, can retard or arrest the progression of the disease with a resultant substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making such nutritional therapy generally available as part of the benefits received under title XVIII of the Social Security Act.

(b) The Secretary shall submit, to the Congress, within one year after the date of the enactment of this Act, a report on the demonstration projects being conducted by the Secretary with respect to waiving the applicable cost sharing amounts which beneficiaries under title XVIII of the Social Security Act have to pay for obtaining a second opinion on having surgery performed. Such report shall include any recommendations for legislative changes in such title which the Secretary finds desirable as a result of such demonstration projects.

(c) The Secretary shall conduct a study of the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under title XVIII of the Social Security Act.

(d) The Secretary shall develop and carry out demonstration projects to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as part of the benefits received under title XVIII of the Social Security Act.

(e) The Secretary shall, in consultation with appropriate professional organizations, conduct a comprehensive study of methods for providing coverage under part B of title XVIII of the Social Security Act for orthopedic shoes for individuals with disabling or deforming conditions who require special fitting considerations to help protect against increasing disability or serious medical complications or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary shall submit to the Congress, no later than July 1, 1981, a report on the findings of this study and such specific legislative recommendations as is appropriate with respect to the utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

(f) The Secretary shall conduct a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under title XVIII of the Social Security Act.

(g) The Secretary shall conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under title XVIII of the Social Security Act for the treatment of various types of foot conditions.

(h) The Secretary shall submit a report on each of the demonstration projects and studies described in subsections (a), (c), (d), (f), and (g). Each such report shall be submitted within twenty-four months of the date of the enactment of this Act and shall contain any recommendations for legislative changes which the Secretary finds desirable as a result of conducting the demonstration project or study with respect to which the report is submitted.

(i) Where any study or demonstration project conducted under this section relates to payments with respect to services furnished by independent practitioners, such study or project shall include an evaluation of the effect of such payments on coordination of care, cost, quality, and the organization in the provision of services and the utilization of services.

(j) Grants, payments under contracts, and other expenditures made for studies and demonstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement,

as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each of such trust funds shall be determined by the Secretary, giving due regard to the purposes of the experiment or project involved.

Temporary Delay on Periodic Interim Payments

SEC. 959. Notwithstanding section 1815(a) of the Social Security Act, in the case of a hospital which is paid periodic interim payments under such section, the Secretary of Health and Human Services shall provide that with respect to the last twenty-one days for which such payments would otherwise be made during fiscal year 1981, such payments shall be deferred until fiscal year 1982.

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SEC. 965. (a) * * *.

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(c)(1) The amendments made by this section shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

Demonstration Projects Relating to the Training of AFDC Recipients as Home Health Aides

SEC. 966. (a) The Secretary of Health and Human Services shall enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health

aides, who shall provide authorized services to elderly or disabled individuals, or other individuals in need of such services, to whom such services, are not otherwise reasonably and actually available or provided, and who would, without the availability of such services, be reasonably anticipated to require institutional care.

(b) For purposes of this section, the term "eligible participant" means an individual who has voluntarily applied for participation and who, at the time such individual enters the project established under this section, has been certified by the appropriate agency of State or local government as being eligible for financial assistance under a State plan approved under part A of title IV of the Social Security Act and as having continuously received such financial assistance during the ninety-day period which immediately precedes the date on which such individual enters such project and who, within such ninety-day period, had not been employed as a homemaker or home health aide.

(c)(1) The Secretary shall enter into agreements under this section with no more than twelve States. Priority shall be given to States which have demonstrated interest in providing services of the type authorized under this section.

(2) A State may apply to enter into an agreement under this section in such manner and at such time as the Secretary may prescribe.

(3) Any State entering into an agreement with the Secretary under this section must—

(A) provide that the demonstration project shall be administered by a State health services agency designated for this purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act);

(B) provide that the agency designated pursuant to subparagraph (A) shall, to the maximum extent feasible, arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities;

(C) establish a formal training program, which meets such standards as the Secretary may establish to assure the adequacy of such program, to prepare eligible participants to provide part-time and intermittent homemaker services or home health aide services to individuals who are elderly, disabled, or otherwise in need of such services;

(D) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides, rendering authorized services, under the supervision of persons determined by the State to be qualified to supervise the performance of such services, to individuals described in subsection (a) at wage levels comparable to the prevailing wage levels in the area for similar work;

(E) provide that such services provided under subparagraph (D) shall be made available without regard to income of the individual requiring such services, but that a reasonable fee will be charged (on a sliding scale basis) for such services provided to individuals who have income in excess of 200 percent of the needs standard in such State under the State plan approved under part A of title IV of the Social Security Act for a household of the same size as such individual's household;

(F) provide for a system of continuing independent professional review by an appropriate panel, which is not affiliated with the entity providing the services involved, to assure that services are provided only to individuals reasonably determined to be in need of such supportive services;

(G) provide for evaluation of the project and review of all agencies providing services under the project;

(H) submit periodic reports to the Secretary as he may require; and

(I) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(4) The number of participants in any project shall not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved to train, employ, and properly utilize eligible participants. Such number may be appropriately modified, subsequently, with the approval of the Secretary.

(5) Any contract with a private bona fide nonprofit agency entered into pursuant to paragraph (3)(D) shall provide for reasonable reimbursement of such agencies for services on a basis proportionate to the amount of time allocated to individuals eligible to receive such services under this section (and, in case such agency is an institution, the amount of the reimbursement shall not exceed the amount of reimbursement which would have been payable if the services involved had been provided by a free-standing agency).

(6) For purposes of this section, a facility of the Veterans' Administration shall, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility which is so considered to be a public agency, of the costs determined under this section which are attributable to such facility, 90 percent shall be paid by the State and 10 percent by the Veterans' Administration.

(d)(1) For purposes of this section, authorized homemaker and home health aide services include part-time or intermittent—

(A) personal care, such as bathing, grooming, and toilet care;

(B) assisting patients having limited mobility;
(C) feeding and diet assistance;
(D) home management, housekeeping, and shopping;
(E) health-oriented recordkeeping;
(F) family planning services; and
(G) simple procedures for identifying potential health problems.

(2) Such authorized services do not include any services performed in an institution, or any services provided under circumstances where institutionalization would be substantially more efficient as a means of providing such services.

(e)(1) Agreements shall be entered into under this section between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as an additional payment under section 1903 of the Social Security Act for each quarter, an amount equal to 90 percent of the reasonable costs incurred (less the Federal share of any related fees collected) by such State during such quarter in carrying out a demonstration project under this section, including reasonable wages and other employment costs of eligible participants employed full time under such project (and, for purposes of determining the amount of such additional payment, the 10 percent referred to in subsection (c)(6), paid by the Veterans' Administration, shall be deemed to be a cost incurred by the State in carrying out such a project).

(2) Demonstration projects under this section shall be of a maximum duration of four years, plus an additional time period of up to six months for planning and development, and up to six months for final evaluation and reporting. Federal funding under this subsection shall not be available for the employment of any eligible participant under the project after such participant has been employed for a period of three years.

(f) For purposes of title IV of the Social Security Act, any eligible participant taking part in a training program under a project authorized under this section shall be deemed to be participating in a work incentive program established by part C of such title.

(g) For the first year (and such additional immediately succeeding period as the State may specify) during which an eligible participant is employed under the project established under this section, such participant shall, notwithstanding any other provision of law, retain any eligiblity for medical assistance under a State plan approved under title XIX of the Social Security Act, and any eligibility for social and supportive services provided under the State plan approved under part A of title IV of such Act, which such participant had at the time such participant entered the training program established under this section.

(h) The Secretary shall submit annual reports to the Congress evaluating the demonstration projects carried out under this section, and shall submit a final report to the Congress not more than six months after he has received the final reports from all States participating in such projects.

(i) The Secretary shall, and is hereby authorized to, waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of this section.

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TITLE X—OTHER SOCIAL SECURITY ACT PROGRAMS; UNEMPLOYMENT COMPENSATION

Waiting Period for Benefits

SEC. 1022. (a) * * *.

(b)(1) Except as provided in paragraph (2), the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning on or after the date of the enactment of this Act.

(2) In the case of a State with respect to which the Secretary of Labor has determined that State legislation is required in order to eliminate its current policy of paying regular compensation to an individual for his first week of otherwise compensable unemployment, the amendments made by this section shall apply in the case of compensation paid to individuals during eligibility periods beginning after the end of the first regularly scheduled session of the State legislature ending more than thirty days after the date of the enactment of this Act.

Benefits on Account of Federal Service To Be Paid by Employing Federal Agency

SEC. 1023. (a) * * *.

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(c) All funds appropriated which are available for the making of payments to States after December 31, 1980, pursuant to agreements entered into under subchapter I of chapter 85 of title 5, United States Code, or for the making of payments after such date of com-

pensation under such subchapter in States which do not have in effect such an agreement, shall be transferred on January 1, 1981, to the Federal Employees Compensation Account established by section 909 of the Social Security Act. On and after such date, all payments described in the preceding sentence shall be made from such Account as provided by section 8509 of title 5, United States Code.

Excerpt from P.L. 96-611

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SEC. 11. (a) * * *.

(b)(1) * * *.

(2) The regulations pertaining to audit criteria (as set forth in 45 CFR 305.20) and the regulations pertaining to penalty for failure to have an effective child support enforcement program (as set forth in 45 CFR 305.50), under the child support program established by title IV-D of the Social Security Act, as in effect on the date of enactment of this Act, shall remain in effect until October 1, 1981.

Public Law 95-19 (H.R. 4800), approved April 12, 1977 (91 Stat. 39). The Emergency Unemployment Compensation Extension Act of 1977.

Public Law 95-30 (H.R. 3477), approved May 23, 1977 (91 Stat. 126). The Tax Reduction and Simplification Act of 1977.

Public Law 95-59 (H.R. 1404), approved June 30, 1977 (91 Stat. 255).

Public Law 95-83 (H.R. 4975), approved August 1, 1977 (91 Stat. 383).

Public Law 95-113 (S. 275), approved September 29, 1977 (91 Stat. 913). The Food and Agriculture Act of 1977.

Public Law 95-142 (H.R. 3), approved October 25, 1977 (91 Stat. 1175). The Medicare-Medicaid Anti-Fraud and Abuse Amendments.

Public Law 95-171 (H.R. 3387), approved November 12, 1977 (91 Stat. 1353).

Public Law 95-210 (H.R. 8422), approved December 13, 1977 (91 Stat. 1485).

Public Law 95-216 (H.R. 9346), approved December 20, 1977 (91 Stat. 1509). The Social Security Amendments of 1977.

Public Law 95-291 (H.R. 11370), approved June 12, 1978 (92 Stat. 304).

Public Law 95-292 (H.R. 8423), approved June 13, 1978 (92 Stat. 307).

Public Law 95-458 (H.R. 1337), approved October 14, 1978 (92 Stat. 1255).

Public Law 95-472 (H.R. 8811), approved October 17, 1978 (92 Stat. 1332).

Public Law 95-478 (H.R. 12255), approved October 18, 1978 (92 Stat. 1513). The Comprehensive Older Americans Act Amendments of 1978.

Public Law 95-482 (H.J. Res 1139), approved October 18, 1978 (92 Stat. 1603).

Public Law 95-524 (S. 2570), approved October 27, 1978 (92 Stat. 1909). The Comprehensive Employment and Training Act Amendments of 1978.

Public Law 95-598 (H.R. 8200) approved November 6, 1978 (92 Stat. 2549).

Public Law 95-600 (H.R. 13511), approved November 6, 1978 (92 Stat. 2763). The Revenue Act of 1978.

Public Law 95-602 (H.R. 12467), approved November 6, 1978 (92 Stat. 2955). The Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978.

Public Law 96–58 (H.R. 4057), approved August 14, 1979 (93 Stat. 389).

Public Law 96–79 (S. 544), approved October 4, 1979 (93 Stat. 592). Health Planning and Resources Development Act of 1979.

Public Law 96–84 (H.R. 3920), approved October 10, 1979 (93 Stat. 653).

Public Law 96–88 (S. 210), approved October 17, 1979 (93 Stat. 669). Department of Education Organization Act.

Public Law 96–167 (H.R. 5224), approved December 29, 1979 (93 Stat. 1275).

Public Law 96–178 (H.R. 3091), approved January 2, 1980 (93 Stat. 1295).

Public Law 96–222 (H.R. 2797), approved April 1, 1980 (94 Stat. 194). Technical Corrections Act of 1979.

Public Law 96–223 (H.R. 3919), approved April 2, 1980 (94 Stat. 229). Crude Oil Windfall Profit Tax Act of 1980.

Public Law 96-249 (S. 1309), approved May 26, 1980 (94 Stat. 357). Food Stamp Act Amendments of 1980.

Public Law 96–265 (H.R. 3236), approved June 9, 1980 (94 Stat. 441). Social Security Disability Amendments of 1980.

Public Law 96–272 (H.R. 3434), approved June 17, 1980 (94 Stat. 500). Adoption Assistance and Child Welfare Act of 1980.

Public Law 96–364 (H.R. 3904), approved September 26, 1980 (94 Stat. 1208). Multiemployer Pension Plan Amendments Act of 1980.

Public Law 96–398 (S. 1177), approved October 7, 1980 (94 Stat. 1564). Mental Health Systems Act.

Public Law 96–403 (H.R. 7670), approved October 9, 1980 (94 Stat. 1709).

Public Law 96–473 (H.R. 5295), approved October 19, 1980 (94 Stat. 2263).

Public Law 96–499 (H.R. 7765), approved December 5, 1980 (94 Stat. 2599). Omnibus Reconciliation Act of 1980 (including as Title IX the Medicare and Medicaid Amendments of 1980 and as Title XI the Revenue Adjustments Act of 1980).

Public Law 96–611 (H.R. 8406), approved December 28, 1980 (94 Stat. 3566).

APPENDIX C

SELECTED MATERIALS RELATED TO TITLE XX PROGRAM

1. CEILING ON FEDERAL MATCHING FUNDS FOR SOCIAL SERVICES UNDER TITLE XX: FISCAL YEARS 1980–82

State	Ceiling applicable to expenditures in fiscal year					
	1980		1981		1982	
	Title XX generally	Additional child care amount	Title XX generally	Additional child care amount	Title XX generally	Additional child care amount
Total	$2,500,000,000	$200,000,000	$2,700,000,000	$200,000,000	$2,760,000,000	$240,000,000
Alabama	42,642,000	3,411,360	46,332,057	3,432,004	47,262,764	4,109,806
Alaska	4,703,000	376,240	4,989,797	369,614	5,091,187	442,712
Arizona	26,533,000	2,122,640	29,146,356	2,158,989	30,722,678	2,671,537
Arkansas	24,776,000	1,982,080	27,066,241	2,004,907	27,336,914	2,377,123
California	253,037,000	20,242,960	276,036,044	20,447,115	284,579,778	24,746,068
Colorado	30,266,000	2,421,280	33,058,950	2,448,811	34,760,515	3,022,654
Connecticut	35,917,000	2,873,360	38,370,669	2,842,272	39,061,691	3,396,889
Delaware	6,725,000	538,000	7,218,490	534,703	7,298,204	634,626
District of Columbia	7,974,000	637,920	8,345,218	618,164	8,226,154	715,318
Florida	97,674,000	7,813,920	106,407,722	7,882,054	111,103,236	9,661,151
Georgia	58,336,000	4,666,880	62,948,204	4,662,829	64,166,508	5,579,696
Hawaii	10,343,000	827,440	11,106,321	822,691	11,473,980	997,737
Idaho	9,903,000	792,240	10,871,071	805,264	11,348,581	986,833
Illinois	129,951,000	10,396,080	139,206,659	10,311,604	140,810,184	12,244,364
Indiana	61,595,000	4,927,600	66,538,876	4,928,806	67,715,291	5,888,286
Iowa	33,270,000	2,661,600	35,857,199	2,656,088	36,390,698	3,164,409
Kansas	26,880,000	2,150,400	29,072,066	2,153,486	29,706,949	2,583,213
Kentucky	39,962,000	3,196,960	43,310,939	3,208,218	44,228,117	3,845,923
Louisiana	45,312,000	3,624,960	49,105,542	3,637,447	50,385,192	4,381,321
Maine	12,538,000	1,003,040	13,508,358	1,000,619	13,756,236	1,196,194
Maryland	47,831,000	3,826,480	51,297,090	3,799,785	52,015,375	4,523,076
Massachusetts	66,818,000	5,345,440	71,491,528	5,295,668	72,342,502	8,290,852
Michigan	105,497,000	8,439,760	113,774,792	8,427,762	115,454,570	10,039,528
Minnesota	45,936,000	8,674,880	49,625,570	3,675,969	50,911,866	4,427,119
Mississippi	27,608,000	2,208,640	29,765,437	2,204,847	30,459,341	2,648,638
Missouri	55,482,000	4,438,560	60,174,719	4,457,386	61,031,540	5,307,091
Montana	8,794,000	703,520	9,719,579	719,969	9,856,337	857,073
Nebraska	18,039,000	1,443,120	19,377,250	1,435,352	19,737,754	1,716,326
Nevada	7,315,000	585,200	8,171,875	605,324	8,802,988	765,477
New Hampshire	9,811,000	784,880	10,784,400	798,844	11,122,863	967,206
New Jersey	84,696,000	6,775,680	90,720,198	6,720,015	91,942,317	7,994,984
New Mexico	13,752,000	1,100,160	15,006,535	1,111,595	15,561,977	1,353,215
New York	207,135,000	16,570,800	219,749,157	16,277,716	221,303,601	19,243,792
North Carolina	63,848,000	5,107,840	69,052,346	5,114,989	70,298,504	6,112,913
North Dakota	7,546,000	603,680	8,072,822	597,987	8,238,694	716,408
Ohio	123,664,000	9,893,120	133,090,134	9,858,528	134,585,330	11,701,333
Oklahoma	32,485,000	2,598,800	35,659,093	2,641,414	36,265,300	3,153,504
Oregon	27,458,000	2,196,640	30,260,701	2,241,535	31,688,248	2,755,500
Pennsylvania	136,191,000	10,895,280	145,484,145	10,776,603	147,105,199	12,791,756
Rhode Island	10,805,000	864,400	11,576,823	857,543	11,649,538	1,013,003
South Carolina	33,236,000	2,658,880	36,129,595	2,676,266	36,766,895	3,197,121
South Dakota	7,962,000	636,960	8,543,324	632,839	8,639,969	751,302
Tennessee	49,680,000	3,974,400	53,946,759	3,996,056	54,924,625	4,776,054
Texas	148,267,000	11,861,360	161,134,524	11,935,891	167,783,441	14,589,865
Utah	14,653,000	1,172,240	16,182,790	1,198,725	17,142,000	1,490,609
Vermont	5,581,000	446,480	6,029,853	446,656	6,182,155	537,579
Virginia	59,341,200	4,747,280	63,740,628	4,721,528	65,169,697	5,666,930
Washington	42,273,000	3,381,840	46,728,269	3,461,353	49,231,524	4,281,002
West Virginia	21,483,000	1,718,640	23,029,831	1,705,913	23,549,873	2,047,815
Wisconsin	53,784,000	4,302,720	57,933,644	4,291,381	59,188,180	5,146,798
Wyoming	4,692,000	375,360	5,249,810	388,876	5,642,940	490,691

Source: Federal Register, July 18, 1980, December 8, 1980

2. MEDIAN INCOME LEVEL APPLICABLE TO TITLE XX: FISCAL YEAR 1981

State	Income for families of 4 persons			
	Median income [1]	80 percent of median income	90 percent of median income	115 percent of median income
Alabama	$18,352	$14,680	$16,517	$21,105
Alaska	27,572	22,058	24,815	31,708
Arizona	20,863	16,690	18,777	23,992
Arkansas	15,669	12,535	14,102	18,019
California	22,294	17,835	20,065	25,638
Colorado	21,778	17,422	19,600	25,045
Connecticut	22,278	17,822	20,050	25,620
Delaware	21,194	16,955	19,075	24,373
District of Columbia	16,769	13,415	15,092	19,284
Florida	18,118	14,494	16,306	20,836
Georgia	19,676	15,741	17,708	22,627
Hawaii	22,475	17,980	20,228	25,846
Idaho	19,042	15,234	17,138	21,896
Illinois	22,081	17,665	19,873	25,393
Indiana	20,556	16,445	18,500	23,639
Iowa	20,800	16,640	18,720	23,920
Kansas	19,792	15,834	17,813	22,760
Kentucky	17,924	14,339	16,132	20,613
Louisiana	18,691	14,953	16,822	21,495
Maine	16,885	13,508	15,197	19,410
Maryland	23,461	18,769	21,115	26,980
Massachusetts	20,512	16,410	18,461	23,586
Michigan	22,063	17,650	19,857	25,372
Minnesota	21,455	17,164	19,310	24,673
Mississippi	16,586	13,269	14,927	19,074
Missouri	19,268	15,414	17,341	22,158
Montana	17,878	14,302	16,090	20,560
Nebraska	19,319	15,455	17,387	22,217
Nevada	21,106	16,885	18,995	24,272
New Hampshire	20,247	16,198	18,222	23,284
New Jersey	22,189	17,751	19,970	25,517
New Mexico	18,738	14,990	16,864	21,549
New York	19,660	15,728	17,694	22,609
North Carolina	18,058	14,446	16,252	20,767
North Dakota	18,789	15,031	16,910	21,607
Ohio	20,950	16,760	18,855	24,098
Oklahoma	19,064	15,251	17,158	21,824
Oregon	21,534	17,227	19,381	24,764
Pennsylvania	19,753	15,802	17,778	22,715
Rhode Island	21,093	16,874	18,984	24,257
South Carolina	18,468	14,774	16,621	21,238
South Dakota	16,897	13,518	15,207	19,432
Tennessee	17,916	14,333	16,124	20,603
Texas	20,455	16,364	18,410	23,523
Utah	20,202	16,162	18,182	23,232
Vermont	18,458	14,766	16,612	21,227
Virginia	20,729	16,583	18,656	23,838
Washington	21,494	17,195	19,345	24,719
West Virginia	18,493	14,794	16,644	21,267
Wisconsin	21,034	16,827	18,931	24,188
Wyoming	22,452	17,962	20,207	25,820

[1] Median income based on 1978 data.

Note: The median income for a family of four in the 50 States and the District of Columbia, applicable to the period Oct. 1, 1980 to Sept. 30, 1981 is $20,428.

Source: Federal Register (Dec. 18, 1979).

2. MEDIAN INCOME LEVEL APPLICABLE TO TITLE XX: FISCAL YEAR 1982

State	Median income [1]	80 percent of median income	90 percent of median income	115 percent of median income
Alabama	$18,613	$14,890	$16,752	$21,405
Alaska	31,037	24,830	27,933	35,693
Arizona	23,000	18,400	20,700	26,450
Arkansas	18,493	14,794	16,644	21,267
California	25,109	20,087	25,598	28,875
Colorado	25,228	20,182	22,705	29,012
Connecticut	24,410	19,528	21,969	28,072
Delaware	21,184	16,947	19,066	24,362
District of Columbia	21,310	17,048	19,179	24,507
Florida	20,757	16,606	18,681	23,871
Georgia	21,578	17,262	19,420	24,815
Hawaii	24,582	19,666	22,124	28,269
Idaho	20,429	16,343	18,386	23,493
Illinois	24,265	19,412	21,839	27,905
Indiana	22,614	18,091	20,353	26,006
Iowa	22,567	18,054	20,310	25,962
Kansas	22,848	18,278	20,563	26,275
Kentucky	19,136	15,310	17,224	22,009
Louisiana	20,166	16,133	18,149	23,191
Maine	18,074	14,459	16,267	20,785
Maryland	24,686	19,749	22,217	28,389
Massachusetts	23,786	19,029	21,407	27,354
Michigan	24,422	19,538	21,980	28,085
Minnesota	24,409	19,527	21,968	28,070
Mississippi	17,672	14,138	15,905	20,323
Missouri	21,294	17,035	19,165	24,488
Montana	20,061	16,041	18,046	23,069
Nebraska	20,749	16,599	18,674	23,861
Nevada	25,457	20,366	22,911	29,276
New Hampshire	22,335	17,868	20,102	25,685
New Jersey	24,640	19,712	22,176	28,336
New Mexico	21,032	16,826	18,929	24,187
New York	21,082	16,866	18,974	24,244
North Carolina	19,648	15,718	17,683	22,595
North Dakota	19,520	15,616	17,568	22,448
Ohio	22,528	18,022	20,275	25,907
Oklahoma	20,852	16,682	18,767	23,980
Oregon	24,031	19,225	21,628	27,636
Pennsylvania	22,314	17,851	20,083	25,661
Rhode Island	21,636	17,309	19,472	24,881
South Carolina	20,154	16,123	18,139	23,177
South Dakota	19,209	15,367	17,288	22,090
Tennessee	19,437	15,550	17,493	22,353
Texas	23,416	18,733	21,074	26,928
Utah	21,250	17,000	19,125	24,438
Vermont	19,314	15,451	17,383	22,211
Virginia	22,976	18,381	20,678	26,422
Washington	24,410	19,528	21,969	28,072
West Virginia	18,876	15,101	16,988	21,707
Wisconsin	23,518	18,814	21,166	27,046
Wyoming	22,673	18,138	20,406	26,074

[1] Median income based on 1979 data.

Note: The median income for a family of four in the 50 States and the District of Columbia, applicable to the period October 1, 1981 to September 30, 1982 is $22,395.

Source: Federal Register (Nov. 24, 1980).

FEDERAL PERCENTAGE AND FEDERAL MEDICAL ASSISTANCE PERCENTAGE, EFFECTIVE OCT. 1, 1981–SEPT. 30, 1983
(FISCAL YEARS 1982 AND 1983)

State	Federal, percentages	Federal medical assistance percentages
Alabama	65.00	71.13
Alaska	50.00	50.00
Arizona	55.41	59.87
Arkansas	65.00	72.15
California	50.00	50.00
Colorado	50.00	52.28
Connecticut	50.00	50.00
Delaware	50.00	50.00
District of Columbia	50.00	50.00
Florida	53.24	57.93
Georgia	62.53	66.28
Guam	50.00	[1] 50.00
Hawaii	50.00	50.00
Idaho	61.59	65.45
Illinois	50.00	50.00
Indiana	51.92	56.73
Iowa	50.39	55.35
Kansas	50.00	52.50
Kentucky	64.38	67.95
Louisiana	63.17	66.05
Maine	65.00	70.62
Maryland	50.00	50.00
Massachusetts	50.00	53.58
Michigan	50.00	50.00
Minnesota	50.00	54.35
Mississippi	65.00	77.36
Missouri	55.98	60.38
Montana	61.49	65.34
Nebraska	53.46	58.22
Nevada	50.00	50.00
New Hampshire	54.91	59.41
New Jersey	50.00	50.00
New Mexico	63.55	67.18
New York	50.00	50.00
North Carolina	64.23	67.81
North Dakota	57.90	62.11
Northern Mariana Islands	50.00	[1] 50.00
Ohio	50.11	55.19
Oklahoma	55.46	59.91
Oregon	50.00	52.81
Pennsylvania	51.98	56.78
Puerto Rico	50.00	[1] 50.00
Rhode Island	53.08	57.37
South Carolina	65.00	70.77
South Dakota	64.65	68.18
Tennessee	65.00	68.93
Texas	50.83	55.15
Utah	65.00	68.64
Vermont	65.00	68.98
Virgin Islands	50.00	[1] 50.00
Virginia	51.93	56.74
Washington	50.00	50.00
West Virginia	64.38	67.95
Wisconsin	53.35	58.02
Wyoming	50.00	50.00

[1] For purposes of section 1118 of the Social Security Act, the percentage used under titles I, X, XIV, and XVI and Part A of title IV will be 75 per centum.

Source: Federal Register (December 1, 1980).

APPENDIX E—VARIABLE AMOUNTS APPLICABLE TO SELECTED PROVISIONS

[Note: See Appendix B for Tax Rates and Bases]

1. Retirement test exempt amounts:

Year	For persons age 65–72 [1]		For persons 65–72 [1]	
	Monthly amount	Annual amount	Monthly amount	Annual amount
1977	$250	$3,000	$250.00	$3,000
1978	270	3,240	333.33	4,000
1979	290	3,480	375.00	4,500
1980	310	3,720	416.67	5,000
1981	340	4,080	458.33	5,500
1982	[2]	[2]	500.00	6,000
1983	[2]	[2]	[2]	[2]

[1] Effective 1982, the age at which the retirement test ceases to apply will be reduced from 72 to 70.
[2] Amount is increased automatically to reflect increases in average wages.

2. Increased benefit levels under automatic provisions:

Year	Percentage increase [1]	Monthly amount of— Special benefits [2] Individual	Special benefits [2] Couple	Special minimum factor [3]	Supplemental security income [4] Individual	Supplemental security income [4] Couple	Supplemental security income [4] Essential person
1975	8.0	$69.60	$104.40	$9.00	$157.70	$236.60	$78.90
1976	6.4	74.10	111.20	9.00	167.80	251.80	84.00
1977	5.9	78.50	117.80	9.00	177.80	266.70	89.00
1978	6.5	83.70	125.60	[6] 11.50	189.40	284.10	94.80
1979	9.9	92.00	138.10	[7]	208.20	312.30	104.20
1980	14.3	105.20	157.90	[7]	238.00	357.00	119.10
1981	[5]	[5]	[5]	[7]	[5]	[5]	[5]

[1] This percentage is applied to increase social security benefits effective June of each year and supplemental security income benefits effective July of each year. (For persons becoming eligible for benefits after 1978, these percentages are applied to increase the benefit determined by the basic formula for years after the 2d year before they reach age 62, die, or become disabled.)
[2] Under secs. 227 and 228.
[3] Under sec. 215(a)(1)(C)(i)(II).
[4] Under sec. 1611.
[5] Automatically increased as Consumer Price Index rises.
[6] Effective for months after December 1978.
[7] Special minimum is determined for years after 1978 by applying the $11.50 factor and increasing the result by subsequent cost-of-living increase percentages. See sec. 7 of this appendix.

3. Formulas for determining benefit amounts under 1977 act:

For Determining Primary Insurance Amount (PIA):	For Determining Maximum Family Benefit
90 percent of Average Indexed Monthly Earnings (AIME) up to "A"; plus	*150 percent of PIA up to "C"; plus*
32 percent of AIME above "A" but not above "B"; plus	*272 percent of PIA above "C" but not above "D"; plus*
15 percent of AIME above "B."	*134 percent of PIA above "D" but not above "E"; plus*
	175 percent of PIA above "E."

Year of worker's 1st eligibility or death [1]	A	B	C	D	E
1979	$180	$1,085	$230	$332	$433
1980	194	1,171	248	358	467
1981	211	1,274	270	390	508
1982	(2)	(2)	(2)	(2)	(2)

[1] The year in which the insured individual first becomes eligible for an old-age insurance benefit (i.e. age 62), or for a disability insurance benefit, or (if he did not become eligible for either) the year of his death
[2] Automatically modified to reflect increases or decreases in wage levels

4. Quarter of coverage amount:

[NOTE: Prior to 1978, an individual generally gained one quarter of coverage under social security for every calendar quarter in which he earned $50 or more in covered wages.]

Year	Annual earnings under social security required for—			
	1 quarter of coverage	2 quarters of coverage	3 quarters of coverage	4 quarters of coverage
1978	$250	$500	$750	$1,000
1979	260	520	780	1,040
1980	290	580	870	1,160
1981	310	620	930	1,240
1982	(1)	(1)	(1)	(1)

[1] Automatically increased as wage levels rise.

5. Average annual wages for indexing purposes:

Year	Average wages	Year	Average wages
1951	$2,799.16	1965	$4,658.72
1952	2,973.32	1966	4,938.36
1953	3,139.44	1967	5,213.44
1954	3,155.64	1968	5,571.76
1955	3,301.44	1969	5,893.76
1956	3,532.36	1970	6,186.24
1957	3,641.72	1971	6,497.08
1958	3,673.80	1972	7,133.80
1959	3,855.80	1973	7,580.16
1960	4,007.12	1974	8,030.76
1961	4,086.76	1975	8,630.92
1962	4,291.40	1976	9,226.48
1963	4,396.64	1977	9,779.44
1964	4,576.32	1978	10,556.03

Year	Average wages
1979	$11,479.46

6. Year of coverage amount:

[NOTE: For purposes of section 215(a)(1)(C)(i)(II), a "year of coverage" for years prior to 1978 equals 25% of the maximum amount of earnings subject to tax as shown in Appendix B.]

Year:	Amount
1978	$4,425
1979	4,725
1980	5,100
1981	5,550
1982	(1)

[1] Increases automatically as wage levels rise.

7. TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS UNDER SUBPARAGRAPH (C)(I)(II) OF SUBSECTION 215(a)(1) BEGINNING JUNE 1980

I (Years of coverage)	II (Primary insurance amount)	III (Maximum family benefits)
If an individual's years of coverage (as determined under sec. 215(a)(1)(C)(ii)) are—	The amount referred to in sec. 215(a)(1)(C)(i)(II) shall be—	And the maximum amount of benefits payable (as provided in sec. 215(i)(2)(D)) on the basis of his or her wages and self-employment income shall be—
11	$14.60	$21.90
12	29.00	43.50
13	43.50	65.30
14	57.90	86.90
15	72.30	108.50
16	86.80	130.20
17	101.20	151.80
18	115.70	173.60
19	130.10	195.20
20	144.50	216.80
21	159.00	238.60
22	173.40	260.20
23	188.00	282.00
24	202.40	303.60
25	216.80	325.20
26	231.30	347.00
27	245.70	368.60
28	260.10	390.20
29	274.60	411.90
30	289.00	433.50

Note: The amounts shown in the above table for years of coverage less than 20 are not payable for June 1980 through December 1980 because the corresponding values shown in column II are less than the $139.50 minimum primary insurance amount payable for that period. For months after December 1980, a special minimum primary insurance amount of $130.10 will be payable.

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS BEGINNING JUNE 1980 FOR INDIVIDUALS TO WHOM PRE-1977 LAW APPLIES—Continued

I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount effective for June 1979)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		825.80	1,751	1,755	943.90	1,651.90
		826.90	1,756	1,760	945.20	1,654.10
		828.00	1,761	1,765	946.50	1,656.40
		829.10	1,766	1,770	947.70	1,658.40
		830.20	1,771	1,775	949.00	1,660.70
		831.30	1,776	1,780	950.20	1,662.90
		832.40	1,781	1,785	951.50	1,665.20
		833.50	1,786	1,790	952.70	1,667.20
		834.60	1,791	1,795	954.00	1,669.50
		835.70	1,796	1,800	955.30	1,671.70
		836.80	1,801	1,805	956.50	1,674.00
		837.90	1,806	1,810	957.80	1,676.00
		839.00	1,811	1,815	959.00	1,678.30
		840.10	1,816	1,820	960.30	1,680.50
		841.20	1,821	1,825	961.50	1,682.80
		842.30	1,826	1,830	962.80	1,684.80
		843.40	1,831	1,835	964.10	1,687.10
		844.50	1,836	1,840	965.30	1,689.30
		845.60	1,841	1,845	966.60	1,691.60
		846.70	1,846	1,850	967.80	1,693.60
		847.80	1,851	1,855	969.10	1,695.90
		848.90	1,856	1,860	970.30	1,698.10
		850.00	1,861	1,865	971.60	1,700.30
		851.10	1,866	1,870	972.90	1,702.40
		852.20	1,871	1,875	974.10	1,704.70
		853.30	1,876	1,880	975.40	1,706.90
		854.40	1,881	1,885	976.60	1,709.10
		855.50	1,886	1,890	977.90	1,711.20
		856.60	1,891	1,895	979.10	1,713.50
		857.70	1,896	1,900	980.40	1,715.70
		858.80	1,901	1,905	981.70	1,717.90
		859.90	1,906	1,910	982.90	1,720.00
		860.90	1,911	1,915	984.10	1,722.10
		861.90	1,916	1,920	985.20	1,724.20
		862.90	1,921	1,925	986.30	1,726.10
		863.90	1,926	1,930	987.50	1,728.20
		864.90	1,931	1,935	988.60	1,730.10
		865.90	1,936	1,940	989.80	1,732.20
		866.90	1,941	1,945	990.90	1,734.10
		867.90	1,946	1,950	992.10	1,736.20
		868.90	1,951	1,955	993.20	1,738.10
		869.90	1,956	1,960	994.30	1,740.20
		870.90	1,961	1,965	995.50	1,742.10
		871.90	1,966	1,970	996.60	1,744.20
		872.90	1,971	1,975	997.80	1,746.10
		873.90	1,976	1,980	998.90	1,748.20
		874.90	1,981	1,985	1,000.10	1,750.10
		875.90	1,986	1,990	1,001.20	1,752.20
		876.90	1,991	1,995	1,002.30	1,754.10
		877.90	1,996	2,000	1,003.50	1,756.20
		878.90	2,001	2,005	1,004.60	1,758.10
		879.90	2,006	2,010	1,005.80	1,760.20
		880.90	2,011	2,015	1,006.90	1,762.10
		881.90	2,016	2,020	1,008.10	1,764.20
		882.90	2,021	2,025	1,009.20	1,766.10
		883.90	2,026	2,030	1,010.30	1,768.20
		884.90	2,031	2,035	1,011.50	1,770.10
		885.90	2,036	2,040	1,012.60	1,772.20
		886.90	2,041	2,045	1,013.80	1,774.10
		887.90	2,046	2,050	1,014.90	1,776.20
		888.90	2,051	2,055	1,016.10	1,778.10
		889.90	2,056	2,060	1,017.20	1,780.20
		890.90	2,061	2,065	1,018.30	1,782.10
		891.90	2,066	2,070	1,019.50	1,784.20
		892.90	2,071	2,075	1,020.60	1,786.10
		893.90	2,076	2,080	1,021.80	1,788.20
		894.90	2,081	2,085	1,022.90	1,790.10
		895.90	2,086	2,090	1,024.10	1,792.20

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS BEGINNING JUNE 1980 FOR INDIVIDUALS TO WHOM PRE-1977 LAW APPLIES—Continued

I		II	III		IV	V
(Primary insurance benefit under 1939 Act, as modified)		(Primary insurance amount effective for June 1979)	(Average monthly wage)		(Primary insurance amount)	(Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		896.90	2,091	2,095	1,025.20	1,794.10
		897.90	2,096	2,100	1,026.30	1,796.20
		898.90	2,101	2,105	1,027.50	1,798.10
		899.90	2,106	2,110	1,028.60	1,800.20
		900.90	2,111	2,115	1,029.80	1,802.10
		901.90	2,116	2,120	1,030.90	1,804.20
		902.90	2,121	2,125	1,032.10	1,806.10
		903.90	2,126	2,130	1,033.20	1,808.20
		904.90	2,131	2,135	1,034.40	1,810.10
		905.90	2,136	2,140	1,035.50	1,812.20
		906.90	2,141	2,145	1,036.60	1,814.10
		907.90	2,146	2,150	1,037.80	1,816.20
		908.90	2,151	2,155	1,038.90	1,818.10
		909.90	2,156	2,160	1,040.10	1,820.20

TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS BEGINNING JANUARY 1980

I (Primary insurance benefit)		II (Primary insurance amount effective for June 1979)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least	But not more than—		
			2,161	2,165	1,041.10	1,822.60
			2,166	2,170	1,042.10	1,823.70
			2,171	2,175	1,043.10	1,825.50
			2,176	2,180	1,044.10	1,827.20
			2,181	2,185	1,045.10	1,829.00
			2,186	2,190	1,046.10	1,830.70
			2,191	2,195	1,047.10	1,832.50
			2,196	2,200	1,048.10	1,834.20
			2,201	2,205	1,049.10	1,836.00
			2,206	2,210	1,050.10	1,837.70
			2,211	2,215	1,051.10	1,839.50
			2,216	2,220	1,052.10	1,841.20
			2,221	2,225	1,053.10	1,843.00
			2,226	2,230	1,054.10	1,844.70
			2,231	2,235	1,055.10	1,846.50
			2,236	2,240	1,056.10	1,848.20
			2,241	2,245	1,057.10	1,850.00
			2,246	2,250	1,058.10	1,851.70
			2,251	2,255	1,059.10	1,853.50
			2,256	2,260	1,060.10	1,855.20
			2,261	2,265	1,061.10	1,857.00
			2,266	2,270	1,062.10	1,858.70
			2,271	2,275	1,063.10	1,860.50
			2,276	2,280	1,064.10	1,862.20
			2,281	2,285	1,065.10	1,864.00
			2,286	2,290	1,066.10	1,865.70
			2,291	2,295	1,067.10	1,867.50
			2,296	2,300	1,068.10	1,869.20
			2,301	2,305	1,069.10	1,871.00
			2,306	2,310	1,070.10	1,872.70
			2,311	2,315	1,071.10	1,874.50
			2,316	2,320	1,072.10	1,876.20
			2,321	2,325	1,073.10	1,878.00
			2,326	2,330	1,074.10	1,879.70
			2,331	2,335	1,075.10	1,881.50
			2,336	2,340	1,076.10	1,883.20
			2,341	2,345	1,077.10	1,885.00
			2,346	2,350	1,078.10	1,886.70
			2,351	2,355	1,079.10	1,888.50
			2,356	2,360	1,080.10	1,890.20
			2,361	2,365	1,081.10	1,892.00
			2,366	2,370	1,082.10	1,893.70
			2,371	2,375	1,083.10	1,895.50
			2,376	2,380	1,084.10	1,897.20
			2,381	2,385	1,085.10	1,899.00
			2,386	2,390	1,086.10	1,900.70
			2,391	2,395	1,087.10	1,902.50
			2,396	2,400	1,088.10	1,904.20
			2,401	2,405	1,089.10	1,906.00
			2,406	2,410	1,090.10	1,907.70
			2,411	2,415	1,091.10	1,909.50
			2,416	2,420	1,092.10	1,911.20
			2,421	2,425	1,093.10	1,913.00
			2,426	2,430	1,094.10	1,914.70
			2,431	2,435	1,095.10	1,916.50
			2,436	2,440	1,096.10	1,918.20
			2,441	2,445	1,097.10	1,920.00
			2,446	2,450	1,098.10	1,921.70
			2,451	2,455	1,099.10	1,923.50
			2,456	2,460	1,100.10	1,925.20
			2,461	2,465	1,101.10	1,927.00
			2,466	2,470	1,102.10	1,928.70
			2,471	2,475	1,103.10	1,930.50

Average Monthly Wage

(b)(1) For the purposes of column III of the table appearing in subsection (a) of this section, an individual's "average monthly wage" shall be the quotient obtained by dividing—

(A) the total of his wages paid in and self-employment income credited to his "benefit computation years" (determined under paragraph (2)), by

(B) the number of months in such years.

(2)(A) The number of an individual's "benefit computation years" shall be equal to the number of elapsed years (determined under para-