''(A) Ambulance services (as described in section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7))).

''(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q))[)].

''(C) Public health services (as defined by the Secretary).

''(D) Other health care services determined appropriate by the Secretary.

''(9) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.''

[Pub. L. 111–148, title III, §3126(b)(1), Mar. 23, 2010, 124 Stat. 426, which directed amendment of section 123 of Pub. L. 111–275, set out above, by striking out subsec. (d)(4)(B)(i)(3)(III), was executed by striking out subsec. (d)(4)(B)(i)(III) to reflect the probable intent of Congress.]

GAO STUDY ON CERTAIN ELIGIBILITY REQUIREMENTS FOR CRITICAL ACCESS HOSPITALS

Pub. L. 106–554, §1(a)(6) [title II, §206], Dec. 21, 2000, 114 Stat. 2763, 2763A–483, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct a study on the eligibility requirements for critical access hospitals under section 1820(c) of the Social Security Act (42 U.S.C. 1395i–4(c)) with respect to limitations on average length of stay and number of beds in such a hospital, including an analysis of—

''(1) the feasibility of having a distinct part unit as part of a critical access hospital for purposes of the medicare program under title XVIII of such Act [this subchapter]; and

''(2) the effect of seasonal variations in patient admissions on critical access hospital eligibility requirements with respect to limitations on average annual length of stay and number of beds.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) together with recommendations regarding—

''(1) whether distinct part units should be permitted as part of a critical access hospital under the medicare program;

''(2) if so permitted, the payment methodologies that should apply with respect to services provided by such units;

''(3) whether, and to what extent, such units should be included in or excluded from the bed limits applicable to critical access hospitals under the medicare program; and

''(4) any adjustments to such eligibility requirements to account for seasonal variations in patient admissions.''

TRANSITION FOR MAF

Pub. L. 105–33, title IV, §4201(c)(6), Aug. 5, 1997, 111 Stat. 374, provided that:

''(A) IN GENERAL.—The Secretary of Health and Human Services shall provide for an appropriate transition for a facility that, as of the date of the enactment of this Act [Aug. 5, 1997], operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508] (42 U.S.C. 1395b–1 note) from such demonstration to the program established under subsection (a) [amending this section]. At the conclusion of the transition period described in subparagraph (B), the Secretary shall end such demonstration.

''(B) TRANSITION PERIOD DESCRIBED.—

''(i) INITIAL PERIOD.—Subject to clause (ii), the transition period described in this subparagraph is the period beginning on the date of the enactment of this Act and ending on October 1, 1998.

''(ii) EXTENSION.—If the Secretary determines that the transition is not complete as of October 1, 1998, the Secretary shall provide for an appropriate extension of the transition period.''

GAO REPORTS

Pub. L. 103–432, title I, §102(a)(4), Oct. 31, 1994, 108 Stat. 4402, directed Comptroller General to submit to Congress, not later than 2 years after Oct. 31, 1994, reports on application of requirements under subsec. (f) of this section that rural primary care hospitals provide inpatient care only to those individuals whose attending physicians certify may reasonably be expected to be discharged within 72 hours after admission and maintain average length of inpatient stay during a year that does not exceed 72 hours, and extent to which such requirements have resulted in such hospitals providing inpatient care beyond their capabilities or have limited ability of such hospitals to provide needed services.

§ 1395i–5. Conditions for coverage of religious nonmedical health care institutional services

(a) In general

Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution and for home health services furnished an individual by a religious nonmedical health care institution only if—

(1) the individual has an election in effect for such benefits under subsection (b); and

(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services, extended care services, or home health services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility, or receiving services from a home health agency, that was not such an institution.

(b) Election

(1) In general

An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

(2) Form

The election form under this subsection shall include the following:

(A) A written statement, signed by the individual (or such individual's legal representative), that—

(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

(3) Revocation

An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revoca-

tion and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this subchapter.

(4) Limitation on subsequent elections

Once an individual's election under this subsection has been made and revoked twice—

(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

(5) Excepted medical treatment

For purposes of this subsection:

(A) Excepted medical treatment

The term ''excepted medical treatment'' means medical care or treatment (including medical and other health services)—

(i) received involuntarily, or

(ii) required under Federal or State law or law of a political subdivision of a State.

(B) Nonexcepted medical treatment

The term ''nonexcepted medical treatment'' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

(c) Monitoring and safeguard against excessive expenditures

(1) Estimate of expenditures

Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) for that fiscal year.

(2) Adjustment in payments

(A) Proportional adjustment

If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

(B) Alternative adjustments

The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures described in paragraph (1) to the trigger level.

(C) Trigger level

For purposes of this subsection—

(i) In general

Subject to adjustment under paragraph (3)(B), the ''trigger level'' for a year is the unadjusted trigger level described in clause (ii).

(ii) Unadjusted trigger level

The ''unadjusted trigger level'' for—

(I) fiscal year 1998, is $20,000,000, or

(II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

(D) Prohibition of administrative and judicial review

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

(E) Effect on billing

Notwithstanding any other provision of this subchapter, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

(3) Monitoring expenditure level

(A) In general

The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

(B) Adjustment in trigger level

(i) In general

If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

(ii) Limitation on carryforward

In no case may the increase effected under clause (i) for a fiscal year exceed $50,000,000.

(d) Sunset

If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

(e) Annual report

At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit

to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under subchapter XIX. Such report shall include—

(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

(2) trends in such level; and

(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.

(Aug. 14, 1935, ch. 531, title XVIII, § 1821, as added Pub. L. 105–33, title IV, § 4454(a)(2), Aug. 5, 1997, 111 Stat. 428; amended Pub. L. 108–173, title VII, § 706(a), Dec. 8, 2003, 117 Stat. 2339.)

AMENDMENTS

2003—Subsec. (a). Pub. L. 108–173, § 706(a)(1), inserted ''and for home health services furnished an individual by a religious nonmedical health care institution'' after ''religious nonmedical health care institution'' in introductory provisions.

Subsec. (a)(2). Pub. L. 108–173, § 706(a)(2), substituted '', extended care services, or home health services'' for ''or extended care services'' and inserted '', or receiving services from a home health agency,'' after ''skilled nursing facility''.

EFFECTIVE DATE

Pub. L. 105–33, title IV, § 4454(d), Aug. 5, 1997, 111 Stat. 431, provided that: ''The amendments made by this section [enacting this section and amending sections 1320a–1, 1320c–11, 1395x, 1396a, and 1396g of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act [42 U.S.C. 1395i–5(b)].''

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR AGED AND DISABLED

§ 1395j. Establishment of supplementary medical insurance program for aged and disabled

There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions 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.

(Aug. 14, 1935, ch. 531, title XVIII, § 1831, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 301; amended Pub. L. 92–603, title II, § 201(a)(3), Oct. 30, 1972, 86 Stat. 1371.)

AMENDMENTS

1972—Pub. L. 92–603 substituted ''aged and disabled individuals'' for ''individuals 65 years of age or over''.

STUDY REGARDING COVERAGE UNDER PART B OF MEDICARE FOR NONREIMBURSABLE SERVICES PROVIDED BY OPTOMETRISTS FOR PROSTHETIC LENSES FOR PATIENTS WITH APHAKIA

Pub. L. 94–182, title I, § 109, Dec. 31, 1975, 89 Stat. 1053, provided that the Secretary of Health, Education, and Welfare conduct a study on the appropriateness of reimbursement under the insurance program established by this part for services performed by optometrists with respect to the provision of prosthetic lenses for patients with aphakia and submit such study to Congress not later than 4 months after Dec. 31, 1975.

STUDY TO DETERMINE FEASIBILITY OF INCLUSION OF CERTAIN ADDITIONAL SERVICES UNDER PART B

Pub. L. 90–248, title I, § 141, Jan. 2, 1968, 81 Stat. 855, directed Secretary to conduct a study relating to inclusion under the supplementary medical insurance program under this part of services of additional types of licensed practitioners performing health services in independent practice and submit such study to Congress prior to Jan. 1, 1969.

§ 1395k. Scope of benefits; definitions

(a) Scope of benefits

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 subparagraphs (E) and (F) of section 1395u(b)(6) of this title; and

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

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) 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 1395x(b) of this title (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,

(ii) services for which payment may be made pursuant to section 1395n(b)(2) of this title,

(iii) services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;[1]

[1] So in original. The semicolon probably should be a comma.