''(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) [100 Stat. 183].

''(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) [100 Stat. 2062].

''(2) DELAY IN APPLICATION TO CURRENT WAIVERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of waivers granted with respect to a PACE program before July 1, 2000, the repeals made by paragraph (1) shall not apply until the end of a transition period (of up to 36 months) that begins on the initial effective date of such regulations, and that allows sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle [subtitle I (§§ 4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title and amending sections 1396b, 1396d, 1396r–5, and 1396v of this title].

''(B) STATE OPTION TO SEEK EXTENSION OF CURRENT PERIOD.—A State may elect to maintain the PACE programs which (as of the date of the enactment of this Act [Aug. 5, 1997]) were operating in the State under the authority described in paragraph (1) until a date (specified by the State) that is not later than 4 years after the initial effective date of regulations described in subsection (a). If a State makes such an election, the repeals made by paragraph (1) shall not apply to the programs until the date so specified, but only so long as such programs continue to operate under the same terms and conditions as apply to such programs as of the date of the enactment of this Act, and subparagraph (A) shall not apply to such programs.''

PACE PROGRAMS; STUDY AND REPORTS

Pub. L. 105–33, title IV, § 4804(a), (b), Aug. 5, 1997, 111 Stat. 551, provided that:

''(a) STUDY.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in sections 1894(a)(8) and 1934(a)(8) of the Social Security Act [42 U.S.C. 1395eee(a)(8), 1396u–4(a)(8)]) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle [subtitle I (§§ 4801–4804) of title IV of Pub. L. 105–33, enacting this section and section 1396u–4 of this title and amending sections 1396b, 1396d, 1396r–5, and 1396v of this title].

''(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under sections 1894(h) and 1934(h) of the Social Security Act [42 U.S.C. 1395eee(h), 1396u–4(h)] with the costs, quality, and access to services of other PACE providers.

''(b) REPORT.—

''(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

''(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

''(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sections 1894(h) and 1934(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

''(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

''(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

''(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.''

§ 1395fff. Prospective payment for home health services

(a) In general

Notwithstanding section 1395x(v) of this title, the Secretary shall provide, for portions of cost reporting periods occurring on or after October 1, 2000, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) System of prospective payment for home health services

(1) In general

The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of August 5, 1997, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this subchapter that exceed the aggregate payments that would be made if such a transition did not occur.

(2) Unit of payment

In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

(3) Payment basis

(A) Initial basis

(i) In general

Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

(I) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for the 12-month period beginning on the date the Secretary implements the system shall be equal to the total amount that would have been made if the system had not

been in effect and if section 1395x(v)(1)(L)(ix) of this title had not been enacted.

(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).

(III) Subject to clause (iii), for periods beginning after the period described in subclause (II), such amount (or amounts) shall be equal to the amount (or amounts) that would have been determined under subclause (I) that would have been made for fiscal year 2001 if the system had not been in effect and if section 1395x(v)(1)(L)(ix) of this title had not been enacted but if the reduction in limits described in clause (ii) had been in effect, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) Reduction

The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits are in effect on September 30, 2000.

(iii) Adjustment for 2014 and subsequent years

(I) In general

Subject to subclause (II), for 2014 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

(II) Transition

The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2017. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of March 23, 2010.

(B) Annual update

(i) In general

The standard prospective payment amount (or amounts) shall be adjusted for fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004) in a prospective manner specified by the Secretary by the home health applicable increase percentage (as defined in clause (ii)) applicable to the fiscal year or year involved.

(ii) Home health applicable increase percentage

For purposes of this subparagraph, the term ''home health applicable increase percentage'' means, with respect to—

(I) each of fiscal years 2002 and 2003, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

(II) for[1] the last calendar quarter of 2003 and the first calendar quarter of 2004, the home health market basket percentage increase;

(III) the last 3 calendar quarters of 2004, and all of 2005[2] the home health market basket percentage increase minus 0.8 percentage points;

(IV) 2006, 0 percent; and

(V) any subsequent year, subject to clauses (v) and (vi), the home health market basket percentage increase.

(iii) Home health market basket percentage increase

For purposes of this subsection, the term ''home health market basket percentage increase'' means, with respect to a fiscal year or year, a percentage (estimated by the Secretary before the beginning of the fiscal year or year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1395ww(b)(3)(B)(iii) of this title is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year or year. Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent.

(iv) Adjustment for case mix changes

Insofar as the Secretary determines that the adjustments under paragraph (4)(A)(i) for a previous fiscal year or year (or estimates that such adjustments for a future fiscal year or year) did (or are likely to) result in a change in aggregate payments

[1] So in original. The word ''for'' probably should not appear.

[2] So in original. Probably should be followed by a comma.

under this subsection during the fiscal year or year that are a result of changes in the coding or classification of different units of services that do not reflect real changes in case mix, the Secretary may adjust the standard prospective payment amount (or amounts) under paragraph (3) for subsequent fiscal years or years so as to eliminate the effect of such coding or classification changes.

(v) Adjustment if quality data not submitted

(I) Adjustment

For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclauses (II) and (IV) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year, and the Medicare Payment Advisory Commission shall carry out the requirements under section 5201(d) of the Deficit Reduction Act of 2005.

(II) Submission of quality data

Subject to subclause (V), for 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

(III) Public availability of data submitted

The Secretary shall establish procedures for making data submitted under subclause (II) and subclause (IV)(aa) available to the public. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public.

(IV) Submission of additional data

(aa) In general

For the year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1395*lll* of this title), as applicable with respect to home health agencies and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent year, in addition to the data described in subclause (II), each home health agency shall submit to the Secretary data on such quality measures and any necessary data specified by the Secretary under such subsection (d)(1).

(bb) Standardized patient assessment data

For 2019 and each subsequent year, in addition to such data described in item (aa), each home health agency shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1395*lll* of this title.

(cc) Submission

Data shall be submitted under items (aa) and (bb) in the form and manner, and at the time, specified by the Secretary for purposes of this clause.

(V) Non-duplication

To the extent data submitted under subclause (IV) duplicates other data required to be submitted under subclause (II), the submission of such data under subclause (IV) shall be in lieu of the submission of such data under subclause (II). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1395*lll* of this title, taking into account the different specified application dates under subsection (a)(2)(E) of such section.

(vi) Adjustments

After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

(I) for 2015 and each subsequent year (except 2018), by the productivity adjustment described in section 1395ww(b)(3)(B)(xi)(II) of this title; and

(II) for each of 2011, 2012, and 2013, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.

(C) Adjustment for outliers

The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.

(4) Payment computation

(A) In general

The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

(i) Case mix adjustment

The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

(ii) Area wage adjustment

The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

(B) Establishment of case mix adjustment factors

The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

(C) Establishment of area wage adjustment factors

The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1395ww(d)(3)(E) of this title.

(5) Outliers

(A) In general

Subject to subparagraph (B), the Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

(B) Program specific outlier cap

The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.

(6) Proration of prospective payment amounts

If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

(c) Requirements for payment information

With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this subchapter unless—

(1) the claim has the unique identifier (provided under section 1395u(r) of this title) for the physician who prescribed the services or made the certification described in section 1395f(a)(2) or 1395n(a)(2)(A) of this title; and

(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1395x(m) of this title, the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments.

(d) Limitation on review

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

(1) the establishment of a transition period under subsection (b)(1);

(2) the definition and application of payment units under subsection (b)(2);

(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

(5) the establishment of case mix and area wage adjustments under subsection (b)(4); and

(6) the establishment of any adjustments for outliers under subsection (b)(5).

(e) Construction related to home health services

(1) Telecommunications

Nothing in this section shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established by this section for such units of service from furnishing services via a telecommunication system if such services—

(A) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician pursuant to section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title; and

(B) are not considered a home health visit for purposes of eligibility or payment under this subchapter.

(2) Physician certification

Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1395f(a)(2)(C) or 1395n(a)(2)(A) of this title for the payment for home health services, whether or not furnished via a telecommunications system.

(Aug. 14, 1935, ch. 531, title XVIII, § 1895, as added Pub. L. 105–33, title IV, § 4603(a), Aug. 5, 1997, 111 Stat. 467; amended Pub. L. 105–277, div. J, title V, § 5101(c)(1), (d)(2), Oct. 21, 1998, 112 Stat. 2681–914; Pub. L. 106–113, div. B, § 1000(a)(6) [title III, §§ 302(b), 303(b), 306, 321(k)(19)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359, 1501A–361, 1501A–362, 1501A–368; Pub. L. 106–554, § 1(a)(6) [title V, §§ 501(a), (c)(1), 504], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, 2763A–531; Pub. L. 108–173, title VII, § 701, Dec. 8, 2003, 117 Stat. 2334; Pub. L. 109–171, title V, § 5201(a), (c), Feb. 8, 2006, 120 Stat. 46; Pub. L. 111–148, title III, §§ 3131(a)(1), (b), 3401(e), title X, §§ 10315(a), 10319(d), Mar. 23, 2010, 124 Stat. 427, 428, 483, 944, 949; Pub. L. 113–185, § 2(c)(1), Oct. 6, 2014, 128 Stat. 1962; Pub. L. 114–10, title IV, § 411(c), Apr. 16, 2015, 129 Stat. 161.)

REFERENCES IN TEXT

Section 5201(d) of the Deficit Reduction Act of 2005, referred to in subsec. (b)(3)(B)(v)(I), is section 5201(d) of title V of Pub. L. 109–171, Feb. 8, 2006, 120 Stat. 47, which is not classified to the Code.

AMENDMENTS

2015—Subsec. (b)(3)(B)(iii). Pub. L. 114–10, §411(c)(1), inserted at end ''Notwithstanding the previous sentence, the home health market basket percentage increase for 2018 shall be 1 percent.''

Subsec. (b)(3)(B)(vi)(I). Pub. L. 114–10, §411(c)(2), inserted ''(except 2018)'' after ''each subsequent year''.

2014—Subsec. (b)(3)(B)(v)(I). Pub. L. 113–185, §2(c)(1)(A), substituted ''subclauses (II) and (IV)'' for ''subclause (II)''.

Subsec. (b)(3)(B)(v)(II). Pub. L. 113–185, §2(c)(1)(B), substituted ''Subject to subclause (V), for 2007'' for ''For 2007''.

Subsec. (b)(3)(B)(v)(III). Pub. L. 113–185, §2(c)(1)(C), inserted ''and subclause (IV)(aa)'' after ''subclause (II)''.

Subsec. (b)(3)(B)(v)(IV), (V). Pub. L. 113–185, §2(c)(1)(D), added subcls. (IV) and (V).

2010—Subsec. (b)(3)(A)(i)(III). Pub. L. 111–148, §3131(a)(1)(A), substituted ''Subject to clause (iii), for periods'' for ''For periods''.

Subsec. (b)(3)(A)(iii). Pub. L. 111–148, §10315(a), substituted ''2014'' for ''2013'' in heading and in subcl. (I), and ''2017'' for ''2016'' in subcl. (II).

Pub. L. 111–148, §3131(a)(1)(B), added cl. (iii).

Subsec. (b)(3)(B)(ii)(V). Pub. L. 111–148, §3401(e)(1), substituted ''clauses (v) and (vi)'' for ''clause (v)''.

Subsec. (b)(3)(B)(vi). Pub. L. 111–148, §3401(e)(2), added cl. (vi).

Subsec. (b)(3)(B)(vi)(II). Pub. L. 111–148, §10319(d), substituted '', 2012, and 2013'' for ''and 2012''.

Subsec. (b)(3)(C). Pub. L. 111–148, §3131(b)(1), substituted ''5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.'' for ''the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).''

Subsec. (b)(5). Pub. L. 111–148, §3131(b)(2), designated existing provisions as subpar. (A), inserted heading, substituted ''Subject to subparagraph (B), the Secretary'' for ''The Secretary'' and ''2.5 percent'' for ''5 percent'', and added subpar. (B).

2006—Subsec. (b)(3)(B)(ii)(III). Pub. L. 109–171, §5201(a)(1), substituted ''all of 2005'' for ''each of 2005 and 2006''.

Subsec. (b)(3)(B)(ii)(IV). Pub. L. 109–171, §5201(a)(2), (4), added subcl. (IV). Former subcl. (IV) redesignated (V).

Pub. L. 109–171, §5201(a)(3), struck out ''2007 and'' before ''any subsequent year''.

Subsec. (b)(3)(B)(ii)(V). Pub. L. 109–171, §5201(a)(3), (c)(1), redesignated subcl. (IV) as (V) and inserted ''subject to clause (v),'' after ''subsequent year,''.

Subsec. (b)(3)(B)(v). Pub. L. 109–171, §5201(c)(2), added cl. (v).

2003—Subsec. (b)(3)(B)(i). Pub. L. 108–173, §701(a)(1), substituted ''fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)'' for ''each fiscal year (beginning with fiscal year 2002)'' and inserted ''or year'' after ''the fiscal year''.

Subsec. (b)(3)(B)(ii)(I). Pub. L. 108–173, §701(a)(2)(A), struck out ''or'' at end.

Subsec. (b)(3)(B)(ii)(II). Pub. L. 108–173, §701(b)(1), struck out ''or'' at end.

Pub. L. 108–173, §701(a)(2)(D), added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (b)(3)(B)(ii)(III). Pub. L. 108–173, §701(b)(4), added subcl. (III). Former subcl. (III) redesignated (IV).

Pub. L. 108–173, §701(a)(2)(B), (C), redesignated subcl. (II) as (III) and substituted ''2004 and any subsequent year'' for ''any subsequent fiscal year''.

Subsec. (b)(3)(B)(ii)(IV). Pub. L. 108–173, §701(b)(2), (3), redesignated subcl. (III) as (IV) and substituted ''2007'' for ''2004''.

Subsec. (b)(3)(B)(iii). Pub. L. 108–173, §701(a)(3), inserted ''or year'' after ''fiscal year'' wherever appearing.

Subsec. (b)(3)(B)(iv). Pub. L. 108–173, §701(a)(4), inserted ''or year'' after ''fiscal year'' wherever appearing and ''or years'' after ''fiscal years''.

Subsec. (b)(5). Pub. L. 108–173, §701(a)(5), inserted ''or year'' after ''fiscal year''.

2000—Subsec. (b)(3)(A)(i)(II). Pub. L. 106–554, §1(a)(6) [title V, §501(a)(3)], added subcl. (II). Former subcl. (II) redesignated (III).

Subsec. (b)(3)(A)(i)(III). Pub. L. 106–554, §1(a)(6) [title V, §501(a)(1), (2)], redesignated subcl. (II) as (III) and substituted ''described in subclause (II)'' for ''described in subclause (I)''.

Subsec. (b)(3)(B)(iv). Pub. L. 106–554, §1(a)(6) [title V, §501(c)(1)], added cl. (iv).

Subsec. (e). Pub. L. 106–554, §1(a)(6) [title V, §504], added subsec. (e).

1999—Subsec. (b)(1). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(19)], made technical amendment to reference in original act which appears in text as reference to August 5, 1997.

Subsec. (b)(3)(A)(i). Pub. L. 106–113, §1000(a)(6) [title III, §302(b)], amended heading and text of cl. (i) generally. Prior to amendment, text read as follows: ''Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''

Subsec. (b)(3)(A)(i)(I). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(1)], which directed that the second sentence of cl. (i) be amended in subcl. (I) by the insertion of ''and if section 1395x(v)(1)(L)(ix) of this title had not been enacted'' before semicolon, was executed by making the insertion before the period at end of subcl. (I) to reflect the probable intent of Congress.

Subsec. (b)(3)(A)(i)(II). Pub. L. 106–113, §1000(a)(6) [title III, §303(b)(2)], inserted ''and if section 1395x(v)(1)(L)(ix) of this title had not been enacted'' after ''if the system had not been in effect''.

Subsec. (b)(3)(B)(ii)(I). Pub. L. 106–113, §1000(a)(6) [title III, §306], substituted ''each of fiscal years 2002 and 2003'' for ''fiscal year 2002 or 2003''.

1998—Subsec. (a). Pub. L. 105–277, §5101(c)(1)(A), substituted ''for portions of cost reporting periods occurring on or after October 1, 2000'' for ''for cost reporting periods beginning on or after October 1, 1999''.

Subsec. (b)(3)(A)(i). Pub. L. 105–277, §5101(c)(1)(B)(i), substituted ''fiscal year 2001'' for ''fiscal year 2000''.

Subsec. (b)(3)(A)(ii). Pub. L. 105–277, §5101(c)(1)(B)(ii), substituted ''September 30, 2000'' for ''September 30, 1999''.

Subsec. (b)(3)(B)(i). Pub. L. 105–277, §5101(d)(2)(A), substituted ''home health applicable increase percentage (as defined in clause (ii))'' for ''home health market basket percentage increase''.

Pub. L. 105–277, §5101(c)(1)(B)(iii), substituted ''fiscal year 2002'' for ''fiscal year 2001''.

Subsec. (b)(3)(B)(ii), (iii). Pub. L. 105–277, §5101(d)(2)(B), (C), added cl. (ii) and redesignated former cl. (ii) as (iii).

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title V, §501(c)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, provided that: ''The

amendment made by paragraph (1) [amending this section] shall apply to episodes concluding on or after October 1, 2001.''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 303(b)] of Pub. L.106–113 applicable to services furnished by home health agencies for cost reporting periods beginning on or after Oct. 1, 1999, see section 1000(a)(6) [title III, § 303(c)] of Pub. L. 106–113, set out as a note under section 1395x of this title.

Amendment by section 1000(a)(6) [title III, § 321(k)(19)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE

Pub. L. 105–33, title IV, § 4603(d), Aug. 5, 1997, 111 Stat. 471, as amended by Pub. L. 105–277, div. J, title V, § 5101(c)(2), Oct. 21, 1998, 112 Stat. 2681–914, provided that: ''Except as otherwise provided, the amendments made by this section [enacting this section and amending sections 1395f, 1395g, 1395k, 1395*l*, 1395u, and 1395y of this title] shall apply to portions of cost reporting periods occurring on or after October 1, 2000.''

STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS

Pub. L. 111–148, title III, § 3131(d), title X, § 10315(b), Mar. 23, 2010, 124 Stat. 429, 944, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

''(A) Methods to potentially revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

''(i) payment adjustments for services that may involve additional or fewer resources;

''(ii) changes to reflect resources involved with providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas;

''(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

''(iv) other issues determined appropriate by the Secretary.

''(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment vulnerabilities associated with implementing potential revisions.

''(C) Whether additional research might be needed.

''(D) Other items determined appropriate by the Secretary.

''(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

''(A) population density and relative patient access to care;

''(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

''(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

''(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.]; and

''(E) other factors determined appropriate by the Secretary.

''(3) REPORT.—Not later than March 1, 2014, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(4) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

''(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

''(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

''(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of the payment adjustments under subparagraph (A).

''(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

''(i) shall not apply to payments for home health services under title XVIII [42 U.S.C. 1395 et seq.] after such period; and

''(ii) shall not be taken into account in calculating the payment amounts applicable for such services after such period.

''(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall conduct the project for a four year period beginning not later than January 1, 2015.

''(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

''(F) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

''(i) provide for an evaluation of the project; and

''(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

''(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection.''

TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA

Pub. L. 108–173, title IV, § 421, Dec. 8, 2003, 117 Stat. 2283, as amended by Pub. L. 109–171, title V, § 5201(b), Feb. 8, 2006, 120 Stat. 46; Pub. L. 111–148, title III, § 3131(c), Mar. 23, 2010, 124 Stat. 428; Pub. L. 114–10, title II, § 210, Apr. 16, 2015, 129 Stat. 151, provided that:

''(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005,

episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and visits ending on or after April 1, 2010, and before January 1, 2018, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary [of Health and Human Services] shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent (or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2018, 3 percent).

''(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

''(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

''(1) shall not apply to episodes and visits ending after such period; and

''(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.''

DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY-CARE SERVICES

Pub. L. 108–173, title VII, §703, Dec. 8, 2003, 117 Stat. 2336, provided that:

''(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary [of Health and Human Services] shall establish a demonstration project (in this section referred to as the 'demonstration project') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day-care facility, to provide medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

''(b) PAYMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day-care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day-care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day-care services furnished under the plan of care.

''(2) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY-CARE SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration project and under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] for home health services. If the Secretary estimates that the total expenditures under the demonstration project and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration project had not been conducted, the Secretary shall adjust the rate of payment to medical adult day-care facilities under paragraph (1) in order to eliminate such excess.

''(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day-care services.

''(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

''(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

''(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day-care services.

''(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

''(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. Not later than 6 months after the completion of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

''(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

''(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

''(i) DEFINITIONS.—In this section:

''(1) HOME HEALTH AGENCY.—The term 'home health agency' has the meaning given such term in section 1861(*o*) of the Social Security Act (42 U.S.C. 1395x(*o*)).

''(2) MEDICAL ADULT DAY-CARE FACILITY.—The term 'medical adult day-care facility' means a facility that—

''(A) has been licensed or certified by a State to furnish medical adult day-care services in the State for a continuous 2-year period;

''(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

''(C) is licensed and certified by the State in which it operates or meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

''(D) provides medical adult day-care services.

''(3) MEDICAL ADULT DAY-CARE SERVICES.—The term 'medical adult day-care services' means—

''(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) [probably means section 1861(m) of the Social Security Act, 42 U.S.C. 1395x(m)] furnished in a medical adult day-care facility;

''(B) a program of supervised activities furnished in a group setting in the facility that—

''(i) meet such criteria as the Secretary determines appropriate; and

''(ii) is designed to promote physical and mental health of the individuals; and

''(C) such other services as the Secretary may specify.

''(4) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual entitled to benefits under part A of this title [probably means part A of title XVIII of the Social Security Act, 42 U.S.C. 1395c et seq.], enrolled under part B of this title [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], or both.''

TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS

Pub. L. 108–173, title VII, §704, Dec. 8, 2003, 117 Stat. 2338, provided that:

''(a) IN GENERAL.—During the period described in subsection (b), the Secretary [of Health and Human Services] may not require, under section 4602(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) [set out as a note under this section] or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] (such information in this section referred to as 'non-medicare/medicaid OASIS information').

''(b) PERIOD OF SUSPENSION.—The period described in this subsection—

''(1) begins on the date of the enactment of this Act [Dec. 8, 2003]; and

''(2) ends on the last day of the second month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

''(c) REPORT.—

''(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

''(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

''(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

''(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003].

''(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.''

MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES

Pub. L. 108–173, title VII, §705, Dec. 8, 2003, 117 Stat. 2339, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

''(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Commission shall submit to Congress a report on the study under subsection (a).''

SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS

Pub. L. 106–554, §1(a)(6) [title V, §502(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–530, provided that:

''(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending section 1395x of this title], for purposes of making payments under section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) for home health services furnished during fiscal year 2001, the Secretary of Health and Human Services shall—

''(A) with respect to episodes and visits ending on or after October 1, 2000, and before April 1, 2001, use the final standardized and budget neutral prospective payment amounts for 60-day episodes and standardized average per visit amounts for fiscal year 2001 as published by the Secretary in the Federal Register on July 3, 2000 (65 Fed. Reg. 41128–41214); and

''(B) with respect to episodes and visits ending on or after April 1, 2001, and before October 1, 2001, use such amounts increased by 2.2 percent.

''(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—The Secretary shall not take the provisions of paragraph (1) into account for purposes of payments, determinations, or budget neutrality adjustments under section 1895 of the Social Security Act.''

TEMPORARY TWO-MONTH PERIODIC INTERIM PAYMENT

Pub. L. 106–554, §1(a)(6) [title V, §503], Dec. 21, 2000, 114 Stat. 2763, 2763A–530, provided that:

''(a) IN GENERAL.—Notwithstanding the amendments made by section 4603(b) of BBA [Pub. L. 105–33, amending section 1395g of this title] (42 U.S.C. 1395fff note), in the case of a home health agency that was receiving periodic interim payments under section 1815(e)(2) of the Social Security Act (42 U.S.C. 1395g(e)(2)) as of September 30, 2000, and that is not described in subsection (b), the Secretary of Health and Human Services shall, as soon as practicable, make a single periodic interim payment to such agency in an amount equal to four times the last full fortnightly periodic interim payment made to such agency under the payment system in effect prior to the implementation of the prospective payment system under section 1895(b) of such Act (42 U.S.C. 1395fff(b)). Such amount of such periodic interim payment shall be included in the tentative settlement of the last cost report for the home health agency under the payment system in effect prior to the implementation of such prospective payment system, regardless of the ending date of such cost report.

''(b) EXCEPTIONS.—The Secretary shall not make an additional periodic interim payment under subsection (a) in the case of a home health agency (determined as of the day that such payment would otherwise be made) that—

''(1) notifies the Secretary that such agency does not want to receive such payment;

''(2) is not receiving payments pursuant to section 405.371 of title 42, Code of Federal Regulations;

''(3) is excluded from the medicare program under title XI of the Social Security Act [42 U.S.C. 1301 et seq.];

''(4) no longer has a provider agreement under section 1866 of such Act (42 U.S.C. 1395cc);

''(5) is no longer in business; or

''(6) is subject to a court order providing for the withholding of medicare payments under title XVIII of such Act [42 U.S.C. 1395 et seq.].''

TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA

Pub. L. 106–554, §1(a)(6) [title V, §508], Dec. 21, 2000, 114 Stat. 2763, 2763A–533, provided that:

''(a) 24-MONTH INCREASE BEGINNING APRIL 1, 2001.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after April 1, 2001, and before April 1, 2003, the Secretary of Health and Human Services shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

''(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).''

CLARIFICATION OF APPLICATION OF TEMPORARY PAYMENT INCREASES FOR 2001

Pub. L. 106–554, §1(a)(6) [title V, §547(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–553, provided that:

''(1) TRANSITIONAL ALLOWANCE FOR FULL MARKETBASKET [SIC] INCREASE.—The payment increase provided under section 502(b)(1)(B) [set out as a note above] shall not apply to episodes and visits ending after fiscal year 2001 and shall not be taken into account in calculating the payment amounts applicable for subsequent episodes and visits.

''(2) TEMPORARY INCREASE FOR RURAL HOME HEALTH SERVICES.—The payment increase provided under section 508(a) [set out as a note above] for the period beginning on April 1, 2001, and ending on September 30, 2002, shall not apply to episodes and visits ending after such period, and shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.''

ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS NOT INCLUDED IN THE INTERIM PAYMENT SYSTEM; GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §301], Nov. 29, 1999, 113 Stat. 1536, 1501A–358, provided that:

''(a) ADJUSTMENT TO REFLECT ADMINISTRATIVE COSTS

''(1) IN GENERAL.—In the case of a home health agency that furnishes home health services to a medicare beneficiary, for each such beneficiary to whom the agency furnished such services during the agency's cost reporting period beginning in fiscal year 2000, the Secretary of Health and Human Services shall pay the agency, in addition to any amount of payment made under section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) for the beneficiary and only for such cost reporting period, an aggregate amount of $10 to defray costs incurred by the agency attributable to data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by reason of section 4602(e) of BBA [the Balanced Budget Act of 1997, Pub. L. 105–33] (42 U.S.C. 1395fff note).

''(2) PAYMENT SCHEDULE

''(A) MIDYEAR PAYMENT.—Not later than April 1, 2000, the Secretary shall pay to a home health agency an amount that the Secretary estimates to be 50 percent of the aggregate amount payable to the agency by reason of this subsection.

''(B) UPON SETTLED COST REPORT.—The Secretary shall pay the balance of amounts payable to an agency under this subsection on the date that the cost report submitted by the agency for the cost reporting period beginning in fiscal year 2000 is settled.

''(3) PAYMENT FROM TRUST FUNDS.—Payments under this subsection shall be made, in appropriate part as specified by the Secretary, from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund.

''(4) DEFINITIONS.—In this subsection:

''(A) HOME HEALTH AGENCY.—The term 'home health agency' has the meaning given that term under section 1861(*o*) of the Social Security Act (42 U.S.C. 1395x(*o*)).

''(B) HOME HEALTH SERVICES.—The term 'home health services' has the meaning given that term under section 1861(m) of such Act (42 U.S.C. 1395x(m)).

''(C) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means a beneficiary described in section 1861(v)(1)(L)(vi)(II) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(vi)(II)).

''(b) GAO REPORT ON COSTS OF COMPLIANCE WITH OASIS DATA COLLECTION REQUIREMENTS.—

''(1) REPORT TO CONGRESS.—

''(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act [Nov. 29, 1999], the Comptroller General of the United States shall submit to Congress a report on the matters described in subparagraph (B) with respect to the data collection requirement of patients of such agencies under the Outcome and Assessment Information Set (OASIS) standard as part of the comprehensive assessment of patients.

''(B) MATTERS STUDIED.—For purposes of subparagraph (A), the matters described in this subparagraph include the following:

''(i) An assessment of the costs incurred by medicare home health agencies in complying with such data collection requirement.

''(ii) An analysis of the effect of such data collection requirement on the privacy interests of patients from whom data is collected.

''(C) AUDIT.—The Comptroller General shall conduct an independent audit of the costs described in subparagraph (B)(i). Not later than 180 days after receipt of the report under subparagraph (A), the Comptroller General shall submit to Congress a report describing the Comptroller General's findings with respect to such audit, and shall include comments on the report submitted to Congress by the Secretary of Health and Human Services under subparagraph (A).

''(2) DEFINITIONS.—In this subsection:

''(A) COMPREHENSIVE ASSESSMENT OF PATIENTS.—The term 'comprehensive assessment of patients' means the rule published by the Health Care Financing Administration that requires, as a condition of participation in the medicare program, a home health agency to provide a patient-specific comprehensive assessment that accurately reflects the patient's current status and that incorporates the Outcome and Assessment Information Set (OASIS).

''(B) OUTCOME AND ASSESSMENT INFORMATION SET.—The term 'Outcome and Assessment Information Set' means the standard provided under the rule relating to data items that must be used in conducting a comprehensive assessment of patients.''

REPORT TO CONGRESS ON NEED FOR REDUCTIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §302(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–360, as amended by Pub. L. 106–554, §1(a)(6) [title V, §501(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–529, provided that: ''Not later than April 1, 2002, the Comptroller General of the United States shall submit to Congress a report analyzing the need for the 15 percent reduction under subsection (b)(3)(A)(ii) of such section [42 U.S.C. 1395fff(b)(3)(A)(ii)], or for any reduction, in the computation of the base payment amounts under the prospective payment system for home health services established under such section.''

STUDY AND REPORT TO CONGRESS REGARDING EXEMPTION OF RURAL AGENCIES AND POPULATIONS FROM INCLUSION IN HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §307], Nov. 29, 1999, 113 Stat. 1536, 1501A–362, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (referred to in this section as 'MedPAC') shall conduct a study to determine the feasibility and advisability of exempting home health services provided by a home health agency (or by others under arrangements with such agency) located in a rural area, or to an individual residing in a rural area, from payment under the prospective payment system for such services established by the Secretary of Health and Human Services in accordance with section 1895 of the Social Security Act (42 U.S.C. 1395fff).

''(b) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that MedPAC determines to be appropriate as a result of such study.''

CASE MIX SYSTEM DEVELOPMENT

Pub. L. 105–33, title IV, §4602(d), Aug. 5, 1997, 111 Stat. 467, provided that: ''The Secretary of Health and Human Services shall expand research on a prospective

payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.''

CASE MIX SYSTEM; SUBMISSION OF DATA

Pub. L. 105–33, title IV, § 4602(e), Aug. 5, 1997, 111 Stat. 467, provided that: ''Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.''

PROSPECTIVE PAYMENT SYSTEM CONTINGENCY

Pub. L. 105–33, title IV, § 4603(e), Aug. 5, 1997, 111 Stat. 471, as amended by Pub. L. 105–277, div. J, title V, § 5101(c)(3), Oct. 21, 1998, 112 Stat. 2681–914, provided that if the Secretary of Health and Human Services did not establish and implement the prospective payment system for home health services described in subsec. (b) of this section for portions of cost reporting periods described in section 4603(d) of Pub. L. 105–33 (set out as a note above), for such portions the Secretary was to provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1395x(v)(1)(L) of this title, as those limits would otherwise have been in effect on Sept. 30, 2000, prior to repeal by Pub. L. 106–113, div. B, § 1000(a)(6) [title III, § 302(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–359.

REPORTS TO CONGRESS REGARDING HOME HEALTH COST CONTAINMENT

Pub. L. 105–33, title IV, § 4616, Aug. 5, 1997, 111 Stat. 475, provided that:

''(a) ESTIMATE.—Not later than October 1, 1997, the Secretary of Health and Human Services shall submit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes an estimate of the outlays that will be made under parts A and B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.] for the provision of home health services during each of fiscal years 1998 through 2002.

''(b) ANNUAL REPORT.—Not later than the end of each of years 1999 through 2002, the Secretary shall submit to such Committees a report that compares the actual outlays under such parts for such services during the fiscal year ending in the year, to the outlays estimated under subsection (a) for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the medicare program or such other methods as will reduce the growth in outlays for home health services under the medicare program.''

§ 1395ggg. Omitted

CODIFICATION

Section, act Aug. 14, 1935, ch. 531, title XVIII, § 1896, as added Pub. L. 105–33, title IV, § 4015(a), Aug. 5, 1997, 111 Stat. 337; amended Pub. L. 106–398, § 1 [[div. A], title VII, § 712(a)(2), (b)–(e)], Oct. 30, 2000, 114 Stat. 1654, 1654A–177, 1654A–178; Pub. L. 107–314, div. A, title VII, § 713, Dec. 2, 2002, 116 Stat. 2589; Pub. L. 108–173, title VII, § 736(c)(8), Dec. 8, 2003, 117 Stat. 2356, authorized the Secretary of Health and Human Services and the Secretary of Defense, acting jointly, to establish a demonstration project for providing medicare health care services to certain medicare-eligible military retirees or dependents in a military treatment facility or by a designated provider, to be conducted during the 4-year period beginning on January 1, 1998.

§ 1395hhh. Health care infrastructure improvement program

(a) Establishment

The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

(b) Application

No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

(c) Selection criteria

(1) In general

The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

(2) Qualifying hospital defined

For purposes of this section, the term ''qualifying hospital'' means a hospital or an entity described in paragraph (3) that—

(A) is engaged in research in the causes, prevention, and treatment of cancer; and

(B) is designated as a cancer center for the National Cancer Institute or is designated by the State legislature as the official cancer institute of the State and such designation by the State legislature occurred prior to December 8, 2003.

(3) Entity described

An entity described in this paragraph is an entity that—

(A) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(B) has at least 1 existing memorandum of understanding or affiliation agreement with a hospital located in the State in which the entity is located; and

(C) retains clinical outpatient treatment for cancer on site as well as lab research and education and outreach for cancer in the same facility.

(d) Projects

A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

(e) State and local permits

The provision of a loan under this section with respect to a project shall not—

(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;