(iv) take into account whether a participant's opioid use disorder care team refers applicable beneficiaries to other suppliers or providers for any opioid use disorder treatment services.

(C) No duplicate payment

The Secretary shall make payments under this paragraph to only one participant for services furnished to an applicable beneficiary during a calendar month.

(2) Incentive payments

(A) In general

Under the Program, the Secretary shall establish a performance-based incentive payment, which shall be paid (using a methodology established and at a time determined appropriate by the Secretary) to participants based on the performance of participants with respect to criteria, as determined appropriate by the Secretary, in accordance with subparagraph (B).

(B) Criteria

(i) In general

Criteria described in subparagraph (A) may include consideration of the following:

(I) Patient engagement and retention in treatment.

(II) Evidence-based medication-assisted treatment.

(III) Other criteria established by the Secretary.

(ii) Required consultation and consideration

In determining criteria described in subparagraph (A), the Secretary shall—

(I) consult with stakeholders, including clinicians in the primary care community and in the field of addiction medicine; and

(II) consider existing clinical guidelines for the treatment of opioid use disorders.

(C) No duplicate payment

The Secretary shall ensure that no duplicate payments under this paragraph are made with respect to an applicable beneficiary.

(f) Multipayer strategy

In carrying out the Program, the Secretary shall encourage other payers to provide similar payments and to use similar criteria as applied under the Program under subsection (e)(2)(C). The Secretary may enter into a memorandum of understanding with other payers to align the methodology for payment provided by such a payer related to opioid use disorder treatment services with such methodology for payment under the Program.

(g) Evaluation

(1) In general

The Secretary shall conduct an intermediate and final evaluation of the program. Each such evaluation shall determine the extent to which each of the purposes described in subsection (b) have been accomplished under the Program.

(2) Reports

The Secretary shall submit to Congress—

(A) a report with respect to the intermediate evaluation under paragraph (1) not later than 3 years after the date of the implementation of the Program; and

(B) a report with respect to the final evaluation under paragraph (1) not later than 6 years after such date.

(h) Funding

(1) Administrative funding

For the purposes of implementing, administering, and carrying out the Program (other than for purposes described in paragraph (2)), $5,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(2) Care management fees and incentives

For the purposes of making payments under subsection (e), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title for each of fiscal years 2021 through 2024.

(3) Availability

Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) Waivers

The Secretary may waive any provision of this subchapter as may be necessary to carry out the Program under this section.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866F, as added Pub. L. 115–271, title VI, § 6042, Oct. 24, 2018, 132 Stat. 3979.)

REFERENCES IN TEXT

Section 223 of the Protecting Access to Medicare Act of 2014, referred to in subsec. (c)(1)(A)(i)(VII), is section 223 of Pub. L. 113–93, which is set out as a note under section 1396a of this title.

§ 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a

hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless—

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a–7a(a) of this title.

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

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a–7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a–7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with quality improvement organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate quality improvement organization (with a contract under part B of subchapter XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term ''emergency medical condition'' means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term ''participating hospital'' means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term ''to stabilize'' means, with respect to an emergency medical condition de-

scribed in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term ''stabilized'' means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term ''transfer'' means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term ''hospital'' includes a critical access hospital (as defined in section 1395x(mm)(1) of this title) and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1867, as added Pub. L. 99–272, title IX, §9121(b), Apr. 7, 1986, 100 Stat. 164; amended Pub. L. 99–509, title IX, §9307(c)(4), Oct. 21, 1986, 100 Stat. 1996; Pub. L. 99–514, title XVIII, §1895(b)(4), Oct. 22, 1986, 100 Stat. 2933; Pub. L. 100–203, title IV, §4009(a)(1), formerly §4009(a)(1), (2), Dec. 22, 1987, 101 Stat. 1330–56, 1330–57; Pub. L. 100–360, title IV, §411(b)(8)(A)(i), July 1, 1988, 102 Stat. 772; Pub. L. 100–485, title VI, §608(d)(18)(E), Oct. 13, 1988, 102 Stat. 2419; Pub. L. 101–239, title VI, §§6003(g)(3)(D)(xiv), 6211(a)–(h), Dec. 19, 1989, 103 Stat. 2154, 2245–2248; Pub. L. 101–508, title IV, §§4008(b)(1)–(3)(A), 4207(a)(1)(A), (2), (3), (k)(3), formerly 4027(a)(1)(A), (2), (3), (k)(3), Nov. 5, 1990, 104 Stat. 1388–44, 1388–117, 1388–124, renumbered and amended Pub. L. 103–432, title I, §160(d)(4), (5)(A), Oct. 31, 1994, 108 Stat. 4444; Pub. L. 105–33, title IV, §4201(c)(1), Aug. 5, 1997, 111 Stat. 373; Pub. L. 108–173, title VII, §736(a)(14), title IX, §944(b), (c)(1), Dec. 8, 2003, 117 Stat. 2355, 2423; Pub. L. 112–40, title II, §261(a)(3)(A), (E), Oct. 21, 2011, 125 Stat. 423; Pub. L. 116–260, div. CC, title I, §125(b)(2)(B), Dec. 27, 2020, 134 Stat. 2966.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 125(b)(2)(B) of Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023. See 2020 Amendment note below.

PRIOR PROVISIONS

A prior section 1395dd, act Aug. 14, 1935, ch. 531, title XVIII, §1867, as added July 30, 1965, Pub. L. 89–97, title I, §102(a), 79 Stat. 329; amended Jan. 2, 1968, Pub. L. 90–248, title I, §164(a), 81 Stat. 873; Oct. 30, 1972, Pub. L. 92–603, title II, §288, 86 Stat. 1457, related to creation, composition, meetings, and functions of the Health Insurance Benefits Advisory Council and the appointment of a Chairman and members thereto, and qualifications, terms of office, compensation, and reimbursement of travel expenses of members, prior to repeal by Pub. L. 98–369, div. B, title III, §2349(a), July 18, 1984, 98 Stat. 1097, eff. July 18, 1984.

AMENDMENTS

2020—Subsec. (e)(5). Pub. L. 116–260 inserted ''and a rural emergency hospital (as defined in section 1395x(kkk)(2) of this title)'' before period at end.

2011—Subsec. (d)(3). Pub. L. 112–40 substituted ''quality improvement'' for ''peer review'' in heading and for ''utilization and quality control peer review'' in text.

2003—Subsec. (d)(1)(B). Pub. L. 108–173, §736(a)(14)(A), substituted ''if the violation is'' for ''if the violation is is'' in concluding provisions.

Subsec. (d)(3). Pub. L. 108–173, §944(c)(1), inserted ''or in terminating a hospital's participation under this subchapter'' after ''in imposing sanctions under paragraph (1)'' and inserted at end ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''

Subsec. (d)(4). Pub. L. 108–173, §944(b), added par. (4).

Subsec. (e)(1)(B). Pub. L. 108–173, §736(a)(14)(B), substituted ''a pregnant woman'' for ''a pregnant women''.

Subsec. (e)(2). Pub. L. 108–173, §736(a)(14)(C), substituted ''means a hospital'' for ''means hospital''.

1997—Subsec. (e)(5). Pub. L. 105–33 substituted ''critical access'' for ''rural primary care''.

1994—Subsec. (d)(3). Pub. L. 103–432, § 160(d)(5)(A), made technical amendment to Pub. L. 101–508, § 4207(a)(1)(A). See 1990 Amendment note below.

1990—Subsec. (c)(2)(C). Pub. L. 101–508, § 4008(b)(3)(A)(iii), substituted ''subsection (d)(1)(C)'' for ''subsection (d)(2)(C)''.

Subsec. (d)(1). Pub. L. 101–508, § 4008(b)(3)(A)(i), (ii), redesignated par. (2) as (1) and struck out former par. (1) which read as follows: ''If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

''(A) termination of its provider agreement under this subchapter in accordance with section 1395cc(b) of this title, or

''(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.''

Subsec. (d)(1)(B). Pub. L. 101–508, § 4207(a)(2), (3), formerly § 4027(a)(2), (3), as renumbered by Pub. L. 103–432, § 160(d)(4), which directed amendment of par. (2)(B) by substituting ''negligently'' for ''knowingly'' and ''is gross and flagrant or is repeated'' for ''knowing and willful or negligent'', was executed by making the substitutions in par. (1)(B) to reflect the probable intent of Congress and the intervening redesignation of par. (2) as (1) by Pub. L. 101–508, § 4008(b)(3)(A)(ii). See above.

Subsec. (d)(2). Pub. L. 101–508, § 4008(b)(3)(A)(ii), redesignated par. (3) as (2). Former par. (2) redesignated (1).

Subsec. (d)(2)(A). Pub. L. 101–508, § 4008(b)(1), (2), substituted ''negligently'' for ''knowingly'' and inserted ''(or not more than $25,000 in the case of a hospital with less than 100 beds)'' after ''$50,000''.

Subsec. (d)(3). Pub. L. 101–508, § 4207(a)(1)(A), formerly § 4027(a)(1)(A), as renumbered and amended by Pub. L. 103–432, § 160(d)(4), (5)(A), added par. (3). Former par. (3) redesignated (2).

Subsec. (i). Pub. L. 101–508, § 4207(k)(3), formerly § 4027(k)(3), as renumbered by Pub. L. 103–432, § 160(d)(4), amended subsec. (i) generally. Prior to amendment, subsec. (i) read as follows: ''A participating hospital may not penalize or take adverse action against a physician because the physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.''

1989—Pub. L. 101–239, § 6211(h)(2)(A), struck out ''active'' before ''labor'' in section catchline.

Subsec. (a). Pub. L. 101–239, § 6211(h)(2)(B), which directed the amendment of subsec. (a) by striking out ''or to determine if the individual is in active labor (within the meaning of section (e)(2))'' was executed by striking out ''or to determine if the individual is in active labor (within the meaning of subsection (e)(2))'' after ''exists''.

Pub. L. 101–239, § 6211(a), substituted ''hospital's emergency department, including ancillary services routinely available to the emergency department,'' for ''hospital's emergency department''.

Subsec. (b). Pub. L. 101–239, § 6211(h)(2)(C), struck out ''active'' before ''labor'' in heading.

Subsec. (b)(1). Pub. L. 101–239, § 6211(h)(2)(D)(i), struck out ''or is in active labor'' after ''emergency medical condition'' in introductory provisions.

Subsec. (b)(1)(A). Pub. L. 101–239, § 6211(h)(2)(D)(ii), struck out ''or to provide for treatment of the labor'' after ''stabilize the medical condition''.

Subsec. (b)(2). Pub. L. 101–239, § 6211(b)(1), inserted ''and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment,'' after ''in that paragraph'', substituted ''and treatment.'' for ''or treatment.'', and inserted at end ''The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.''

Subsec. (b)(3). Pub. L. 101–239, § 6211(b)(2), inserted ''and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer,'' after ''subsection (c)'' and inserted at end ''The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.''

Subsec. (c). Pub. L. 101–239, § 6211(g)(1)(A), substituted ''individual'' for ''patient'' in heading.

Subsec. (c)(1). Pub. L. 101–239, § 6211(c)(4), (g)(1)(B), (h)(2)(E), in introductory provisions, substituted ''an individual'' for ''a patient'', ''subsection (e)(3)(B))'' for ''subsection (e)(4)(B)) or is in active labor'', and ''the individual'' for ''the patient'', and inserted at end ''A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.''

Subsec. (c)(1)(A)(i). Pub. L. 101–239, § 6211(c)(1), (g)(1)(B), substituted ''the individual'' for ''the patient'', ''the individual's behalf'' for ''the patient's behalf'', and ''after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility'' for ''requests that the transfer be effected''.

Subsec. (c)(1)(A)(ii). Pub. L. 101–239, § 6211(c)(2)(B), (3), (g)(1)(B), substituted ''has signed a certification that based upon the information available at the time of transfer'' for '', or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time'' and ''individual and, in the case of labor, to the unborn child'' for ''individual's medical condition''.

Subsec. (c)(1)(A)(iii). Pub. L. 101–239, § 6211(c)(2)(A), (C), (D), added cl. (iii).

Subsec. (c)(2)(A). Pub. L. 101–239, § 6211(c)(5), added subpar. (A). Former subpar. (A) redesignated (B).

Subsec. (c)(2)(B). Pub. L. 101–239, § 6211(c)(5)(A), (g)(1)(B), redesignated subpar. (A) as (B) and substituted ''the individual'' for ''the patient'' in cls. (i) and (ii). Former subpar. (B) redesignated (C).

Subsec. (c)(2)(C). Pub. L. 101–239, § 6211(c)(5)(A), (d), redesignated subpar. (B) as (C) and substituted ''sends to'' for ''provides'' and ''all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(2)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment'' for ''with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital''. Former subpar. (C) redesignated (D).

Subsec. (c)(2)(D). Pub. L. 101–239, § 6211(c)(5)(A), redesignated subpar. (C) as (D). Former subpar. (D) redesignated (E).

Subsec. (c)(2)(E). Pub. L. 101–239, § 6211(c)(5)(A), (g)(1)(B), redesignated subpar. (D) as (E) and substituted ''individuals'' for ''patients''.

Subsec. (d)(2)(B). Pub. L. 101–239, § 6211(e)(1), amended subpar. (B) generally. Prior to amendment, subpar. (B) read as follows: ''The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1395u(j)(2) of this title, except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.''

Subsec. (d)(2)(C). Pub. L. 101–239, § 6211(e)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: ''As used in this paragraph, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

''(i) is employed by, or under contract with, the participating hospital, and

''(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the indi-

vidual, or transfers of the individual, with respect to which the violation occurred.''

Subsec. (e)(1). Pub. L. 101–239, §6211(h)(1)(A), substituted ''means—'' and subpars. (A) and (B) for ''means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

''(A) placing the patient's health in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.''

Subsec. (e)(2). Pub. L. 101–239, §6211(h)(1)(B), (E), redesignated par. (3) as (2) and struck out former par. (2) which defined ''active labor''.

Subsec. (e)(3). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (4) as (3). Former par. (3) redesignated (2).

Subsec. (e)(4). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (e)(4)(A). Pub. L. 101–239, §6211(h)(1)(C), substituted ''emergency medical condition described in paragraph (1)(A)'' for ''emergency medical condition'', ''likely to result from or occur during'' for ''likely to result from'', and ''from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta)'' for ''from a facility''.

Subsec. (e)(4)(B). Pub. L. 101–239, §6211(h)(1)(D), inserted ''described in paragraph (1)(A)'' after ''emergency medical condition'', ''or occur during'' after ''to result from'', and '', or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)'' after ''from a facility''.

Subsec. (e)(5). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (6) as (5). Former par. (5) redesignated (4).

Pub. L. 101–239, §6211(g)(2), substituted ''an individual'' for ''a patient'' in two places.

Subsec. (e)(6). Pub. L. 101–239, §6211(h)(1)(E), redesignated par. (6) as (5).

Pub. L. 101–239, §6003(g)(3)(D)(xiv), added par. (6).

Subsecs. (g) to (i). Pub. L. 101–239, §6211(f), added subsecs. (g) to (i).

1988—Subsec. (d)(1). Pub. L. 100–360, §411(b)(8)(A)(i), amended Pub. L. 100–203, §4009(a)(2), see 1987 Amendment note below.

Subsec. (d)(2). Pub. L. 100–360, §411(b)(8)(A)(i), as amended by Pub. L. 100–485, §608(d)(18)(E), amended Pub. L. 100–203, §4009(a)(1), see 1987 Amendment note below.

1987—Subsec. (d)(1). Pub. L. 100–203, §4009(a)(2), which directed insertion of a provision related to imposing the sanction described in section 1395u(j)(2)(A) of this title, was amended generally by Pub. L. 100–360, §411(b)(8)(A)(i), so that it does not amend par. (1).

Subsec. (d)(2). Pub. L. 100–203, §4009(a)(1), as amended by Pub. L. 100–360, §411(b)(8)(A)(i), as amended by Pub. L. 100–485, §608(d)(18)(E), substituted subpars. (A) and (B) for ''In addition to the other grounds for imposition of a civil money penalty under section 1320a–7a(a) of this title, a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation.'', designated second sentence as subpar. (C), substituted ''this paragraph'' for ''the previous sentence'', and redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (C).

1986—Subsec. (b)(2), (3). Pub. L. 99–509 struck out ''legally responsible'' after ''individual (or a''.

Subsec. (e)(3). Pub. L. 99–514 struck out ''and has, under the agreement, obligated itself to comply with the requirements of this section'' after ''section 1395cc of this title''.

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 applicable to items and services furnished on or after Jan. 1, 2023, see section 125(g) of Pub. L. 116–260, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to contracts entered into or renewed on or after Jan. 1, 2012, see section 261(e) of Pub. L. 112–40, set out as a note under section 1320c of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title IX, §944(c)(2), Dec. 8, 2003, 117 Stat. 2423, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to terminations of participation initiated on or after the date of the enactment of this Act [Dec. 8, 2003].''

EFFECTIVE DATE OF 1997 AMENDMENT

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

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4008(b)(1)–(3)(A) of Pub. L. 101–508 applicable to actions occurring on or after the first day of the sixth month beginning after Nov. 5, 1990, see section 4008(b)(4) of Pub. L. 101–508, set out as a note under section 1395cc of this title.

Amendment by section 4207(a)(1)(A) of Pub. L. 101–508 effective on the first day of the first month beginning more than 60 days after Nov. 5, 1990, see section 4207(a)(1)(C) of Pub. L. 101–508, as amended, set out as a note under section 1320c–3 of this title.

Pub. L. 101–508, title IV, §4207(a)(4), formerly §4027(a)(4), Nov. 5, 1990, 104 Stat. 1388–118, as renumbered and amended by Pub. L. 103–432, title I, §160(d)(4), (5)(B), Oct. 31, 1994, 108 Stat. 4444, provided that: ''The amendments made by paragraphs (2) and (3) [amending this section] shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act [Nov. 5, 1990].''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6211(i), Dec. 19, 1989, 103 Stat. 2249, provided that: ''The amendments made by this section [amending this section] shall take effect on the first day of the first month that begins more than 180 days after the date of the enactment of this Act [Dec. 19, 1989], without regard to whether regulations to carry out such amendments have been promulgated by such date.''

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–203, title IV, §4009(a)(2), formerly §4009(a)(3), Dec. 22, 1987, 101 Stat. 1330–57, as redesignated by Pub. L. 100–360, title IV, §411(b)(8)(A)(ii), July 1, 1988, 102 Stat. 772, provided that: ''The amendments made by this subsection [amending this section] shall apply to actions occurring on or after the date of the enactment of this Act [Dec. 22, 1987].''

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Con-

solidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

EFFECTIVE DATE

Pub. L. 99–272, title IX, § 9121(c), Apr. 7, 1986, 100 Stat. 167, provided that: ''The amendments made by this section [enacting this section and amending section 1395cc of this title] shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act [Apr. 7, 1986].''

SHORT TITLE

This section is popularly known as the Emergency Medical Treatment and Labor Act (EMTALA).

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP

Pub. L. 108–173, title IX, § 945, Dec. 8, 2003, 117 Stat. 2423, provided that:

''(a) ESTABLISHMENT.—The Secretary [of Health and Human Services] shall establish a Technical Advisory Group (in this section referred to as the 'Advisory Group') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term 'EMTALA' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

''(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

''(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

''(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

''(3) 2 shall represent patients;

''(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

''(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

''(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

''(1) shall review EMTALA regulations;

''(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

''(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

''(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

''(d) ADMINISTRATIVE MATTERS.—

''(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

''(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

''(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

''(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).''

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Pub. L. 108–173, title X, § 1011, Dec. 8, 2003, 117 Stat. 2432, provided that:

''(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary [of Health and Human Services] $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

''(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

''(b) STATE ALLOTMENTS.—

''(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

''(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

''(i) the total amount available for allotments under this paragraph for the fiscal year; and

''(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

''(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

''(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

''(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

''(i) the total amount available for allotments under this paragraph for the fiscal year; and

''(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

''(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

''(c) USE OF FUNDS.—

''(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

''(2) DETERMINATION OF PAYMENT AMOUNTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this para-

graph shall be an amount determined by the Secretary that is equal to the lesser of—

''(i) the amount that the provider demonstrates was incurred for the provision of such services; or

''(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

''(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

''(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

''(A) may establish different methodologies for types of eligible providers;

''(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

''(C) shall provide for the election by a hospital to receive either payments to the hospital for—

''(i) hospital and physician services; or

''(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

''(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

''(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

''(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

''(A) Undocumented aliens.

''(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

''(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a 'laser visa') issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

''(d) APPLICATIONS; ADVANCE PAYMENTS.—

''(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

''(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

''(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

''(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE PROVIDER.—The term 'eligible provider' means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization).

''(2) ELIGIBLE SERVICES.—The term 'eligible services' means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

''(3) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

''(4) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

''(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(6) STATE.—The term 'State' means the 50 States and the District of Columbia.''

INSPECTOR GENERAL STUDY OF PROHIBITION ON HOSPITAL EMPLOYMENT OF PHYSICIANS

Pub. L. 101–508, title IV, § 4008(c), Nov. 5, 1990, 104 Stat. 1388–44, directed Secretary of Health and Human Services (acting through Inspector General of Department of Health and Human Services) to conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act (this section) relating to the examination and treatment of individuals with an emergency medical condition and women in labor, with Secretary to submit a report to Congress on the study not later than 1 year after Nov. 5, 1990.

EX. ORD. NO. 13952. PROTECTING VULNERABLE NEWBORN AND INFANT CHILDREN

Ex. Ord. No. 13952, Sept. 25, 2020, 85 F.R. 62187, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. Every infant born alive, no matter the circumstances of his or her birth, has the same dignity and the same rights as every other individual and is entitled to the same protections under Federal law. Such laws include the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd, which guarantees, in hospitals that have an emergency department, each individual's right to an appropriate medical screening examination and to either stabilizing treatment or an appropriate transfer. They also include section 504 of the Rehabilitation Act [of 1973] (Rehab Act), 29 U.S.C. 794, which prohibits discrimination against individuals with disabilities by programs and activities receiving Federal funding. In addition, the Born-Alive Infants Protection Act [of 2002], 1 U.S.C. 8, makes clear that all infants born alive are individuals for purposes of these and other Federal laws and are therefore afforded the same legal protections as any other person. Together, these laws help protect infants born alive from discrimination in the provision of medical treatment, including infants who require emergency medical treatment, who are premature, or who are born with disabilities. Such infants are entitled to meaningful and non-discriminatory access to medical

examination and services, with the consent of a parent or guardian, when they present at hospitals receiving Federal funds.

Despite these laws, some hospitals refuse the required medical screening examination and stabilizing treatment or otherwise do not provide potentially lifesaving medical treatment to extremely premature or disabled infants, even when parents plead for such treatment. Hospitals might refuse to provide treatment to extremely premature infants—born alive before 24 weeks of gestation—because they believe these infants may not survive, may have to live with long-term disabilities, or may have a quality-of-life deemed to be inadequate. Active treatment of extremely premature infants has, however, been shown to improve their survival rates. And the denial of such treatment, or discouragement of parents from seeking such treatment for their children, devalues the lives of these children and may violate Federal law.

SEC. 2. *Policy*. It is the policy of the United States to recognize the human dignity and inherent worth of every newborn or other infant child, regardless of prematurity or disability, and to ensure for each child due protection under the law.

SEC. 3. (a) The Secretary of Health and Human Services (Secretary) shall ensure that individuals responsible for all programs and activities under his jurisdiction that receive Federal funding are aware of their obligations toward infants, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment, under EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act. In particular, the Secretary shall ensure that individuals responsible for such programs and activities are aware that they are not excused from complying with these obligations, including the obligation to provide an appropriate medical screening examination and stabilizing treatment or transfer, when extremely premature infants are born alive or infants are born with disabilities. The Secretary shall also ensure that individuals responsible for such programs and activities are aware that they may not unlawfully discourage parents from seeking medical treatment for their infant child solely because of their infant child's disability. The Secretary shall further ensure that individuals responsible for such programs and activities are aware of their obligations to provide stabilizing treatment that will allow the infant patients to be transferred to a more suitable facility if appropriate treatment is not possible at the initial location.

(b) The Secretary shall, as appropriate and consistent with applicable law, ensure that Federal funding disbursed by the Department of Health and Human Services is expended in full compliance with EMTALA and section 504 of the Rehab Act, as interpreted consistent with the Born-Alive Infants Protection Act, as reflected in the policy set forth in section 2 of this order.

(i) The Secretary shall, as appropriate and to the fullest extent permitted by law, investigate complaints of violations of applicable Federal laws with respect to infants born alive, including infants who have an emergency medical condition in need of stabilizing treatment or infants with disabilities whose parents seek medical treatment for their infants. The Secretary shall also clarify, in an easily understandable format, the process by which parents and hospital staff may submit such complaints for investigation under applicable Federal laws.

(ii) The Secretary shall take all appropriate enforcement action against individuals and organizations found through investigation to have violated applicable Federal laws, up to and including terminating Federal funding for non-compliant programs and activities.

(c) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding and National Institutes of Health research dollars for programs and activities conducting research to develop treatments that may improve survival—especially survival without impairment—of infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(d) The Secretary shall, as appropriate and consistent with applicable law, prioritize the allocation of Department of Health and Human Services discretionary grant funding to programs and activities, including hospitals, that provide training to medical personnel regarding the provision of life-saving medical treatment to all infants born alive, including premature infants or infants with disabilities, who have an emergency medical condition in need of stabilizing treatment.

(e) The Secretary shall, as necessary and consistent with applicable law, issue such regulations or guidance as may be necessary to implement this order.

SEC. 4. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 1395ee. Practicing Physicians Advisory Council; Council for Technology and Innovation

(a) Repealed. Pub. L. 111–148, title III, § 3134(b)(2), Mar. 23, 2010, 124 Stat. 435

(b) Council for Technology and Innovation

(1) Establishment

The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as ''CMS'').

(2) Composition

The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) Duties

The Council shall coordinate the activities of coverage, coding, and payment processes under this subchapter with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) Executive Coordinator for Technology and Innovation

The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this subchapter.