

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.”

Pub. L. 104-191, title II, §271(c), Aug. 21, 1996, 110 Stat. 2036, provided that:

“(1) NO PENALTIES.—Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(A)] for any act or omission that occurred during the transition period (as defined in paragraph (4)) and that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

“(2) LIMITATION ON LEGAL ACTION.—Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action—

“(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and

“(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act to any act or omission with respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

“(3) DISCLOSURE CONDITION.—In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act that is sold or issued on or after the effective date of statements under section 171(d)(3)(C) of the Social Security Act Amendments of 1994 [Pub. L. 103-432, set out below] and before the end of the 30-day period beginning on the date of the enactment of this Act [Aug. 21, 1996], paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act (as in effect before the date of the enactment of this Act).

“(4) TRANSITION PERIOD.—In this subsection, the term ‘transition period’ means the period beginning on November 5, 1991, and ending on the date of the enactment of this Act.”

APPLICABILITY OF DISCLOSURE REQUIREMENT

Pub. L. 103-432, title I, §171(d)(3)(C), Oct. 31, 1994, 108 Stat. 4448, provided that: “The requirement of a disclosure under section 1882(d)(3)(C)(ii) of the Social Security Act [42 U.S.C. 1395ss(d)(3)(C)(ii)] shall not apply to an application made for a policy or plan before 60 days after the date the Secretary of Health and Human Services publishes or promulgates all the statements under section 1882(d)(3)(D) of such Act.”

STATE REGULATORY PROGRAMS

Pub. L. 103-432, title I, §171(m), Oct. 31, 1994, 108 Stat. 4451, provided that:

“(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section [amending this section and sections 1320c-3, 1395b-2, and 1395b-4 of this title, repealing section 1395zz of this title, and enacting and amending provisions set out as notes under this section], the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act [42 U.S.C. 1395ss] due solely to failure to make such change until the date specified in paragraph (4).

“(2) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act [Oct. 31, 1994], the National Association of Insurance Commissioners (in this subsection referred to as the ‘NAIC’) modifies its 1991 NAIC Model Regulation (adopted in July 1991) to conform to the amendments made by this section and to

delete from section 15C the exception which begins with ‘unless’, such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

“(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the 1991 Regulation for the purposes of section 1882 of the Social Security Act.

“(4) DATE SPECIFIED.—

“(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

“(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

“(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

“(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

“(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

“(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.”

EVALUATION OF 1990 AMENDMENTS

Pub. L. 101-508, title IV, §4358(d), Nov. 5, 1990, 104 Stat. 1388-137, provided that: “The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section [amending this section and section 1320c-3 of this title] and shall report to Congress on such evaluation by not later than January 1, 1995.”

§ 1395ss-1. Clarification

Any health insurance policy that provides reimbursement for expenses incurred for items and services for which payment may be made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] but which are not reimbursable by reason of the applicability of deductibles, coinsurance, copayments or other limitations imposed by a Medicare Advantage plan (including a Medicare Advantage private fee-for-service plan) under part C of such title [42 U.S.C. 1395w-21 et seq.] shall comply with the requirements of section 1882(o) of the such¹ Act (42 U.S.C. 1395ss(o)).

(Pub. L. 110-275, title I, §104(c), July 15, 2008, 122 Stat. 2502.)

REFERENCES IN TEXT

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Title XVIII of the Act is classified generally to this subchapter. Part C of title XVIII of the Act is classified to section 1395w-21 et seq. of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

¹ So in original.

CODIFICATION

Section was enacted as part of the Medicare Improvements for Patients and Providers Act of 2008, and not as part of the Social Security Act which comprises this chapter.

§ 1395tt. Hospital providers of extended care services

(a) Hospital facility agreements; reasonable costs of services

(1) Any hospital which has an agreement under section 1395cc of this title may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(2)(A) Notwithstanding any other provision of this subchapter, payment to any hospital (other than a critical access hospital) for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of—

(I) the number of patient-days during the year for which the services were furnished, and

(II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under subsections (a) through (d) of section 1395yy of this title for subsequent cost reporting periods and up to and including such calendar year) under this subchapter to freestanding skilled nursing facilities in the region (as defined in section 1395ww(d)(2)(D) of this title) in which the facility is located.

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(3) Notwithstanding any other provision of this subchapter, a critical access hospital shall be paid for covered skilled nursing facility services furnished under an agreement entered into under this section on the basis of equal to 101 percent of the reasonable costs of such services (as determined under section 1395x(v) of this title).

(b) Eligible facilities

The Secretary may not enter into an agreement under this section with any hospital unless, except as provided under subsection (g), the hospital is located in a rural area and has less than 100 beds.

(c) Terms and conditions of facility agreements

An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1395cc of this title and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1395cc of this title; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1395cc of this title. A hospital with respect to which an agreement under this section has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(d) Post-hospital extended care services

Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1395cc of this title; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this subchapter (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1395cc of this title.

(e) Reimbursement for routine hospital services

During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement due for routine services from all classes of long-term care patients (including this subchapter, subchapter XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine this subchapter reimbursement for routine hospital services.

(f) Conditions applicable to skilled nursing facilities

A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1395i-3 of this title. Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.