EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100–485 effective as if originally included in 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.

Amendment by section 103 of Pub. L. 100–360 effective Jan. 1, 1989, except as otherwise provided, and applicable to inpatient hospital deductible for 1989 and succeeding years, to care and services furnished on or after Jan. 1, 1989, to premiums for January 1989 and succeeding months, and to blood or blood cells furnished on or after Jan. 1, 1989, see section 104(a) of Pub. L. 100–360, set out as a note under section 1395d of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(b)(8)(D) of 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 1986 AMENDMENT

Section 9124(b) of Pub. L. 99–272 provided that:

''(1) The amendment made by subsection (a)(3) [amending this section] shall apply to premiums paid for months beginning with July 1986.

''(2) In applying that amendment, months (before, during, or after April 1986) in which an individual was required to pay a premium increased under the section that was so amended shall be taken into account in determining the month in which the premium will no longer be subject to an increase under that section as so amended.''

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by section 2315(e) of Pub. L. 98–369 effective as though included in the enactment of the Social Security Amendments of 1983, Pub. L. 98–21, see section 2315(g) of Pub. L. 98–369, set out as an Effective and Termination Dates of 1984 Amendments note under section 1395ww of this title.

Amendment by section 2354(b)(3), (4) of Pub. L. 98–369 effective July 18, 1984, but not to be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date, see section 2354(e)(1) of Pub. L. 98–369, set out as a note under section 1320a–1 of this title.

EFFECTIVE DATE OF 1983 AMENDMENT; TRANSITIONAL RULE

Amendment by Pub. L. 98–21 applicable to premiums for months beginning with January 1984, but for months after June 1983 and before January 1984, the monthly premium for June 1983 shall apply to individuals enrolled under parts A and B of this subchapter, see section 606(c) of Pub. L. 98–21, set out as a note under section 1395r of this title.

SPECIAL ENROLLMENT PROVISIONS FOR MERCHANT SEAMEN

Pub. L. 97–248, title I, § 125, Sept. 3, 1982, 96 Stat. 365, provided that:

''(a) Any individual who—

''(1) was entitled to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [section 249(a) of this title] (as in effect on September 30, 1981), including such entitlement on the basis of continuing medical care under 42 C.F.R. § 32.17, at any time during the period beginning on March 10, 1981, and ending on October 1, 1981, and

''(2) as of September 30, 1981, was eligible under section 1818(a) or section 1836 of the Social Security Act [this section or section 1395*o* of this title] to enroll in the insurance program established by part A or part B, respectively, of title XVIII of that Act [this subchapter] (hereinafter in this section referred to as the 'respective program'),

may enroll (if not otherwise enrolled) in the respective program during the period beginning on the first day of the first month beginning at least 20 days after the date of the enactment of this Act [Sept. 3, 1982] and ending on December 31, 1982.

''(b)(1) The coverage period under the respective program of an individual who enrolls under subsection (a) shall begin—

''(A) on the first day of the month following the month in which the individual enrolls, or

''(B) on October 1, 1981, if the individual files a request for this subparagraph to apply and pays the monthly premiums for the months so covered.

''(2) The coverage period under the respective program of an individual described in subsection (a) who enrolled in the respective program before the enrollment period described in that subsection shall be retroactively extended to October 1, 1981, if the individual files a request before January 1, 1983, for such retroactive extension and pays the monthly premiums for the months so covered.

''(c)(1) For purposes of section 1839(d) of the Social Security Act [section 1395r(d) of this title] with respect to the monthly premium for months after September 1981, if an individual described in subsection (a) has enrolled in the insurance program under part B of title XVIII of the Social Security Act [part B of this subchapter] at any time before the end of the enrollment period described in subsection (a), any month (before the end of that enrollment period) in which he was not enrolled in that program shall not be treated as a month in which he could have been enrolled in the program.

''(2) Paragraph (1) shall not apply to an individual—

''(A) if the individual has enrolled in the insurance program before March 10, 1981, unless the enrollment was terminated solely because the individual lost eligibility to be so enrolled, or

''(B) unless the individual applies for the benefit of such paragraph before January 1, 1983.

''(d)(1) The Secretary of Health and Human Services, beginning as soon as possible but not later than 30 days after the date of the enactment of this Act [Sept. 3, 1982], shall provide for the dissemination of information—

''(A) to unions and other associations representing or assisting seamen,

''(B) to offices enrolling individuals under the respective programs, and

''(C) to such other entities and in such a manner as will effectively inform individuals eligible for benefits under this section,

concerning the special benefits provided under this section.

''(2) An individual may establish that the individual was entitled at a date to medical, surgical, and dental treatment and hospitalization under section 322(a) of the Public Health Service Act [section 249(a) of this title] (as in effect before October 1, 1981) by providing—

''(A) documentation relating to the status under which the individual was provided care in (or under arrangements with) a Public Health Service facility on that date,

''(B) the individual's seamen's papers covering that date, or

''(C) such other reasonable documentation as the Secretary may require.''

§ 1395i–2a. Hospital insurance benefits for disabled individuals who have exhausted other entitlement

(a) Eligibility

Every individual who—

(1) has not attained the age of 65;

(2)(A) has been entitled to benefits under this part under section 426(b) of this title, and

(B)(i) continues to have the disabling physical or mental impairment on the basis of which the individual was found to be under a disability or to be a disabled qualified railroad retirement beneficiary, or (ii) is blind (within the meaning of section 416(i)(1) of this title), but

(C) whose entitlement under section 426(b) of this title ends due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title); and

(3) is not otherwise entitled to benefits under this part,

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

(b) Enrollment

(1) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(2) The individual's initial enrollment period shall begin with the month in which the individual receives notice that the individual's entitlement to benefits under section 426(b) of this title will end due solely to the individual having earnings that exceed the substantial gainful activity amount (as defined in section 423(d)(4) of this title and shall end 7 months later.

(3) There shall be a general enrollment period during the period beginning on January 1 and ending on March 31 of each year (beginning with 1990).

(c) Coverage period

(1) The period (in this subsection referred to as a ''coverage period'') during which an individual is entitled to benefits under the insurance program under this part shall begin on whichever of the following is the latest:

(A) In the case of an individual who enrolls under subsection (b)(2) of this section before the month in which the individual first satisfies subsection (a) of this section, the first day of such month.

(B) In the case of an individual who enrolls under subsection (b)(2) of this section in the month in which the individual first satisfies subsection (a) of this section, the first day of the month following the month in which the individual so enrolls.

(C) In the case of an individual who enrolls under subsection (b)(2) of this section in the month following the month in which the individual first satisfies subsection (a) of this section, the first day of the second month following the month in which the individual so enrolls.

(D) In the case of an individual who enrolls under subsection (b)(2) of this section more than one month following the month in which the individual first satisfies subsection (a) of this section, the first day of the third month following the month in which the individual so enrolls.

(E) In the case of an individual who enrolls under subsection (b)(3) of this section, the July 1 following the month in which the individual so enrolls.

(2) An individual's coverage period under this section shall continue until the individual's enrollment is terminated as follows:

(A) As of the month following the month in which the Secretary provides notice to the individual that the individual no longer meets the condition described in subsection (a)(2)(B) of this section.

(B) As of the month following the month in which the individual files notice that the individual no longer wishes to participate in the insurance program established by this part.

(C) As of the month before the first month in which the individual becomes eligible for hospital insurance benefits under section 426(a) or 426–1 of this title.

(D) As of a date, determined under regulations of the Secretary, for nonpayment of premiums.

The regulations under subparagraph (D) may provide a grace period of not longer than 90 days, which may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period. Termination of coverage under this section shall result in simultaneous termination of any coverage affected under any other part of this subchapter.

(3) The provisions of subsections (h) and (i) of section 1395p of this title apply to enrollment and nonenrollment under this section in the same manner as they apply to enrollment and nonenrollment and special enrollment periods under section 1395i–2 of this title.

(d) Payment of premiums

(1)(A) Premiums for enrollment under this section shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe, and shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

(B)(i) Subject to clause (ii), such premiums shall be payable for the period commencing with the first month of an individual's coverage period and ending with the month in which the individual dies or, if earlier, in which the individual's coverage period terminates.

(ii) Such premiums shall not be payable for any month in which the individual is eligible for benefits under this part pursuant to section 426(b) of this title.

(2) The provisions of subsections (d) through (f) of section 1395i–2 of this title (relating to premiums) shall apply to individuals enrolled under this section in the same manner as they apply to individuals enrolled under that section.

(Aug. 14, 1935, ch. 531, title XVIII, §1818A, as added Pub. L. 101–239, title VI, §6012(a)(2), Dec. 19, 1989, 103 Stat. 2161; amended Pub. L. 101–508, title IV, §4008(m)(3)(C), Nov. 5, 1990, 104 Stat. 1388–54.)

AMENDMENTS

1990—Subsec. (d)(1)(A). Pub. L. 101–508, §4008(m)(3)(C)(i), inserted ''for enrollment under this section'' after ''Premiums''.

Subsec. (d)(1)(C). Pub. L. 101–508, §4008(m)(3)(C)(ii), struck out subpar. (C) which read as follows: ''For purposes of applying section 1395r(g) of this title and sec-

tion 59B(f)(1)(B)(i) of the Internal Revenue Code of 1986, any reference to section 1395i–2 of this title shall be deemed to include a reference to this section.''

EFFECTIVE DATE

Section 6012(b) of Pub. L. 101–239 provided that: ''The amendments made by this section [enacting this section and amending section 1395i–2 of this title] shall take effect on the date of the enactment of this Act [Dec. 19, 1989], but shall not apply so as to provide for coverage under part A of title XVIII of the Social Security Act [this part] for any month before July 1990.''

§ 1395i–3. Requirements for, and assuring quality of care in, skilled nursing facilities

(a) "Skilled nursing facility" defined

In this subchapter, the term ''skilled nursing facility'' means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care, or

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(*l*) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;

(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State