

Table of Contents

PART I. MEDICARE

Subpart A. GENERAL PROVISIONS

CHAPTER 1. INTRODUCTION

I. SCOPE AND PURPOSE

§ 1:1 Overview

II. WHERE TO FIND THE LAW

§ 1:8 General Accounting Office (GAO) reports

§ 1:10 Health insurance manuals transferred to CMS Online Manual System

§ 1:11 Rule-making power under the Administrative Procedures Act (APA)

§ 1:12 Unpublished agency rules

III. PERSONS COVERED UNDER PART A OF THE MEDICARE ACT

§ 1:18 Persons needing hospice care

IV. BENEFITS PROVIDED UNDER PART A OF THE MEDICARE ACT

§ 1:20 Overview

§ 1:21 Hospital benefits

VI. BENEFITS PROVIDED UNDER PART B OF THE MEDICARE ACT

§ 1:29 Fee schedules

VII. ADMINISTRATION OF THE MEDICARE ACT

§ 1:30 Overview

§ 1:31 District and branch office operations

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 1:32 State agency operations
- § 1:33 Office of Hearings and Appeals
- § 1:34 Peer Review Organizations—Generally
- § 1:39 Health and safety standards—Overview

VIII. REPORTING REQUIREMENTS

- § 1:48 Cost report information disclosure

IX. MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

- § 1:51 Overview
- § 1:53 Administrative reform
- § 1:55 Criminal kickbacks, bribes or rebating

XI. SUMMARY OF IMPORTANT MEDICARE PROVISIONS

- § 1:63 Liability for furnishing noncovered services
- § 1:64 Hospital inpatients' "Bill of Rights" statement
- § 1:65 Premiums, deductibles, and copayments
- § 1:66 Benefit notice
- § 1:67 Secondary payer—Generally
- § 1:70 Secondary payer—Statutes, regulations and case law pertaining to the secondary payer program
- § 1:72 Secondary payer—Government's subrogation right—Generally
- § 1:73 Secondary payer—Government's subrogation right—Workers' compensation claims
- § 1:74 Secondary payer—Government's subrogation right—Subrogation based on benefit payment
- § 1:76 Secondary payer—Double damages—Private cause of action
- § 1:78 Secondary payer—Recovery of conditional payments
- § 1:91 Secondary payer—Direct payment to hospital by auto insurance carrier
- § 1:94 Secondary payer—Preemption of state law dispute
- § 1:98 Nonreimbursable expenses
- § 1:109 Early and periodic screening, diagnosis and treatment program
- § 1:110 Employer group health plans
- § 1:111 Federal Claims Collection Act
- § 1:115 Utilization and quality control organizations area designations *[Retitled]*
- § 1:117 Ability to direct treatment

XIII. SUBROGATION

TABLE OF CONTENTS

§ 1:120 Overview

**XIV. HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT 1996
(HIPAA)**

B. ADMINISTRATIVE SIMPLIFICATION

- § 1:124 Definitions—42 U.S.C.A. § 1320d
- § 1:128 Use and disclosure of protected health information
- § 1:131 Person(s) with access to protected health information
- § 1:139 Exceptions—Treatments required by law
- § 1:149 Notification requirements pertaining to family
members and interested parties
- § 1:159.50 Disclosure use of health information without consent
or authorization—Public health activities—Im-
munization of student or prospective student *[New]*
- § 1:161 Disclosure use of health information without consent
or authorization—Health oversight activities
- § 1:169 Disclosure use of health information without consent
or authorization—Workers' compensation claims
- § 1:173 Effect of state law on HIPAA operations
- § 1:175 Form SSA-827

**XV. MEDICARE IMPROVEMENT ACT OF 2006
(PUB. L. NO. 109-432) *[New]***

- § 1:176 Medicare improved quality and provider payments *[New]*
- § 1:177 Medicare beneficiary protections *[New]*
- § 1:178 Medicare program integrity efforts *[New]*
- § 1:179 Medicaid and other health provisions *[New]*

**XVI. MEDICARE IMPROVEMENTS FOR
PATIENTS AND PROVIDERS ACT OF
2008 (PUB. L. NO. 110-275) *[New]***

A. OVERVIEW *[New]*

- § 1:180 Medicare Improvements for Patients and Providers Act of
2008 (MIPPA), Pub. L. No. 110-275 *[New]*

**B. MEDICARE BENEFICIARY
IMPROVEMENTS *[New]***

1. Prevention, Mental Health and Marketing

- § 1:181 Improvements to coverage of preventative services *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 1:182 Elimination of discriminatory copayment rates for Medicare outpatient psychiatric services *[New]*
- § 1:183 Prohibitions and limitations on certain sales and marketing activities under Medicare advantage plans and prescription drug plans *[New]*
- § 1:184 Improvements to the Medigap program *[New]*

2. Low Income Programs

- § 1:185 Extension of qualifying individual (QI) programs (low-income programs) *[New]*
- § 1:186 Application of full low-income subsidy (LIS) assets test under Medicare Savings Program *[New]*
- § 1:187 Eliminating barriers to enrollment *[New]*
- § 1:188 Elimination of Medicare Part D late enrollment penalties paid by subsidy eligible individuals *[New]*
- § 1:189 Eliminating application of estate recovery *[New]*
- § 1:190 Exemptions from income and resources for determination of eligibility for low-income subsidy *[New]*
- § 1:191 Judicial review of decisions of the Commissioner of Social Security under the Medicare Part D low-income subsidy program *[New]*
- § 1:192 Translation of model form *[New]*
- § 1:193 Medicare enrollment assistance *[New]*

C. MEDICARE PROVISIONS RELATING TO PART A *[New]*

- § 1:194 Expansion and extension of the Medicare Rural Hospital Flexibility Program *[New]*
- § 1:195 Rebasing for sole community hospitals *[New]*
- § 1:196 Demonstration project on community health integration models in certain rural counties *[New]*
- § 1:197 Extension of the reclassification of certain hospitals *[New]*
- § 1:198 Revocation of unique deeming authority of the Joint Commission *[New]*

D. MEDICARE PROVISIONS RELATING TO PART B *[New]*

1. Physician's Services

- § 1:199 Physician payment, efficiency, and quality improvements *[New]*
- § 1:200 Incentives for electronic prescribing *[New]*
- § 1:201 Expanding access to primary care services *[New]*
- § 1:202 Extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule *[New]*
- § 1:203 Imaging provisions *[New]*

TABLE OF CONTENTS

- § 1:204 Extension of treatment or certain physician pathology services under Medicare *[New]*
- § 1:205 Accommodation of physicians ordered to active duty in the Armed Services *[New]*
- § 1:206 Adjustment for Medicare mental health services *[New]*
- § 1:207 Improvements for Medicare anesthesia teaching programs *[New]*

2. Other Payment and Coverage Improvements

- § 1:208 Extension of exceptions process for Medicare therapy caps *[New]*
- § 1:209 Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals *[New]*
- § 1:210 Speech-language pathology services *[New]*
- § 1:211 Payment and coverage improvements for patients with chronic obstructive pulmonary disease and other conditions *[New]*
- § 1:212 Clinical laboratory tests *[New]*
- § 1:213 Improved access to ambulance services *[New]*
- § 1:214 Extension and expansion of the Medicare hold harmless provision under the prospective payment for hospital outpatient department (HOPD) services for certain hospitals *[New]*
- § 1:215 Clarification of payment for clinical laboratory tests furnished by critical access hospitals *[New]*
- § 1:216 Adding certain entities as originating sites for payment of telehealth services *[New]*
- § 1:217 Medicare Payment Advisory Commission (MedPAC) study and report on improving chronic care demonstration improvement *[New]*
- § 1:218 Increases of FQHC payment limits *[New]*
- § 1:219 Kidney disease education and awareness provisions *[New]*
- § 1:220 Renal dialysis provisions *[New]*
- § 1:221 Delay in and reform of Medicare DMEPOS competitive acquisition program *[New]*
- § 1:222 Subtitle D—Provisions relating to Part C phase-out of indirect medical education (IME) *[New]*
- § 1:223 Revisions to requirements for Medicare Advantage private fee-for-service plans *[New]*
- § 1:224 Revisions to quality improvement programs *[New]*
- § 1:225 Revisions relating to specialized Medicare Advantage plans for special needs individuals *[New]*
- § 1:226 Limitation on out-of-pocket costs for dual eligible's and qualified Medicare beneficiaries enrolled in a specialized Medicare Advantage plan for special needs individuals *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 1:227 Adjustment to the Medicare Advantage stabilization fund *[New]*
- § 1:228 MedPAC study and report on quality measures *[New]*
- § 1:229 MedPAC study and report on Medicare Advantage payments *[New]*

E. MEDICARE PROVISION RELATING TO PART D—IMPROVING PHARMACY ACCESS *[New]*

- § 1:230 Prompt payments by prescription drug plans and MA-PD plans under Part D *[New]*
- § 1:231 Submission of claims by pharmacies located in or contracting with long term care facilities *[New]*
- § 1:232 Regular update of prescription drug pricing standard *[New]*
- § 1:233 Inclusion of barbiturates and benzodiazepines as covered Part D drugs *[New]*
- § 1:234 Formulary requirements with respect to certain categories or classes of drugs *[New]*
- § 1:235 Use of Part D data *[New]*
- § 1:236 Revision of definition of medically accepted indication for drugs *[New]*
- § 1:237 Contract with a consensus-based entity regarding performance measurement *[New]*
- § 1:238 Cost-sharing for clinical trials *[New]*
- § 1:239 Addressing health care disparities *[New]*
- § 1:240 Demonstration to improve care to previously uninsured *[New]*
- § 1:241 Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare *[New]*
- § 1:242 Medicare improvement funding *[New]*
- § 1:243 Inclusions of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program *[New]*
- § 1:244 Extension of transitional medical assistance (TMA) and abstinence education program *[New]*
- § 1:245 Medicaid DSH extension *[New]*
- § 1:246 Pharmacy reimbursement under Medicaid *[New]*
- § 1:247 Review of administrative claim determinations *[New]*
- § 1:248 County Medicaid health insuring organization *[New]*

F. MISCELLANEOUS *[New]*

- § 1:249 Extension of TANF supplemental grants *[New]*
- § 1:250 Seventy percent federal matching for foster care and adoption assistance for the District of Columbia *[New]*

TABLE OF CONTENTS

- § 1:251 Extension of special diabetes grant programs *[New]*
- § 1:252 IOM reports on best practices for conducting systematic reviews of clinical effectiveness research and for developing clinical protocols *[New]*

XVII. THE MEDICARE IVIG ACCESS AND STRENGTHENING MEDICARE AND REPAYING TAXPAYER ACT OF 2102 (PUB. L. NO. 112-242) *[New]*

A. OVERVIEW *[New]*

- § 1:253 Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 *[New]*

B. MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT *[New]*

- § 1:254 Establishment of demonstration project *[New]*
- § 1:255 Report to Congress *[New]*

C. STRENGTHENING MEDICARE SECONDARY PAYER RULES *[New]*

- § 1:256 Notification of expected payment *[New]*
- § 1:257 Access to claims information through a CMS website *[New]*
- § 1:258 Use of web download during protected period as basis for final conditional amount *[New]*
- § 1:259 Resolution of discrepancies *[New]*
- § 1:260 Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans *[New]*

D. FISCAL EFFICIENCY AND REVENUE NEUTRALITY *[New]*

- § 1:261 Exception to repayment requirements *[New]*
- § 1:262 Calculation and publication of threshold amount *[New]*
- § 1:263 Report to congress *[New]*
- § 1:264 Discretionary civil monetary penalty *[New]*
- § 1:265 Regulations for civil money penalties *[New]*
- § 1:266 Use of Social Security numbers and other identifying information *[New]*
- § 1:267 Statute of limitations *[New]*

XVIII. PROTECTING ACCESS TO MEDICARE

ACT OF 2014 (PUB. L. NO. 113-93)
[New]

A. OVERVIEW *[New]*

§ 1:268 Protecting Access to Medicare Act of 2014 *[New]*

B. MEDICARE EXTENDERS *[New]*

- § 1:269 Physician payment update *[New]*
- § 1:270 Extension of floor on Medicare work geographic adjustment *[New]*
- § 1:271 Extension of exceptions process for Medicare therapy caps *[New]*
- § 1:272 Extension of ambulance add-ons *[New]*
- § 1:273 Extension of increased inpatient hospital payment adjustment for certain low-volume hospital *[New]*
- § 1:274 Extension of the Medicare-Dependent Hospital (MDH) program *[New]*
- § 1:275 Extension for specialized Medicare Advantage plans for special needs individuals *[New]*
- § 1:276 Extension of Medicare reasonable cost contracts *[New]*
- § 1:277 Extension of funding for quality measure endorsement, input, and selection *[New]*
- § 1:278 Extension of funding outreach and assistance for low-income programs *[New]*
- § 1:279 Extension of the two-midnight rule *[New]*
- § 1:280 Technical correction concerning long-term care hospitals *[New]*
- § 1:281 Additional moratorium exception for certain long-term care hospitals *[New]*

C. MEDICAID AND CHIP EXTENSIONS
[New]

- § 1:282 Extension of Qualifying Individual program *[New]*
- § 1:283 Temporary extension of Transitional Medical Assistance *[New]*
- § 1:284 Extension of Medicaid and CHIP express lane option *[New]*

D. SKILLED NURSING FACILITIES *[New]*

- § 1:285 Readmission measures *[New]*
- § 1:286 Valued based purchasing *[New]*
- § 1:287 Valued based purchasing—Federal per diem rate *[New]*
- § 1:288 Valued based purchasing—Publication of scores *[New]*
- § 1:289 Valued based purchasing—No administrative or judicial review *[New]*

TABLE OF CONTENTS

§ 1:290 Valued based purchasing—Congressional Report *[New]*

E. ESTABLISHMENT OF MEDICARE PAYMENT RATES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS AND NEW ADVANCED DIAGNOSTIC LABORATORY TESTS *[New]*

- § 1:291 Reporting of private sector payment rates for the establishment of Medicare payment rates *[New]*
- § 1:292 Payment for clinical diagnostic laboratory tests—Use of private payor rate information to determine Medicare payment rates *[New]*
- § 1:293 Payment for new tests that are not advanced diagnostic laboratory tests *[New]*
- § 1:294 Payment for new advanced diagnostic laboratory tests *[New]*
- § 1:295 Coding for new tests *[New]*
- § 1:296 Expert advisory panel *[New]*
- § 1:297 Coverage of clinical diagnostic laboratory tests *[New]*
- § 1:298 Implementation *[New]*
- § 1:299 GAO study and report on implementation of new payment rates for clinical diagnostic laboratory tests *[New]*
- § 1:300 Monitoring of Medicare expenditures and implementation of new payment system for laboratory tests *[New]*

F. END STAGE RENAL DISEASE (ERSD) PROSPECTIVE PAYMENT SYSTEM *[New]*

- § 1:301 Delay of implementation of oral-only policy *[New]*
- § 1:302 Mitigation of the application of adjustment to bundled payment rate *[New]*
- § 1:303 Drug designations *[New]*
- § 1:304 Quality measures related to conditions treated by oral-only drugs under the ERSD quality incentive program *[New]*
- § 1:305 Audits of cost reports of ERSD providers as recommended by MEDPAC *[New]*

G. QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY DIAGNOSTIC IMAGING AND PROMOTING EVIDENCE-BASED CARE *[New]*

- § 1:306 Quality incentives to promote patient safety and public health in computed tomography *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 1:307 Recognizing appropriate use criteria for certain imaging services *[New]*
- § 1:308 Mechanisms for consultation on applicable appropriate use criteria *[New]*
- § 1:309 Consultation with applicable appropriate use criteria *[New]*
- § 1:310 Identification of outlier ordering professionals *[New]*

H. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE *[New]*

- § 1:311 Ensuring accurate valuation of services under the physician fee schedule *[New]*
- § 1:312 Alternative approaches to establishing practice expense relative values *[New]*
- § 1:313 Identification of potentially misvalued codes *[New]*
- § 1:314 Target for relative value adjustments for misvalued services *[New]*
- § 1:315 Relative values within groups of services *[New]*
- § 1:316 GAO study and report on relative value scale update *[New]*
- § 1:317 Adjustment to Medicare payment localities in California *[New]*

I. ADDITIONAL MEDICARE PROVISIONS *[New]*

- § 1:318 Using funding from transitional fund for sustainable growth rate reform *[New]*
- § 1:319 Realignment of the Medicare sequester for fiscal year 2024 *[New]*

J. ADDITIONAL MEDICAID PROVISIONS *[New]*

- § 1:320 Disproportionate share hospital (DSH) allotments *[New]*
- § 1:321 Certified community behavioral health clinic *[New]*

XIX. IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT (PUB. L. NO. 113-185) *[New]*

A. OVERVIEW *[New]*

- § 1:322 Improving Medicare Post-Acute Care Transformation Act *[New]*

B. STANDARDIZATION OF POST-ACUTE

TABLE OF CONTENTS

CARE DATA *[New]*

- § 1:323 Statutory definitions *[New]*
- § 1:324 Requirement for standardized assessment data *[New]*
- § 1:325 Quality measures *[New]*
- § 1:326 Resource use and other measures *[New]*
- § 1:327 Measurement implementation phases; selection of quality measures and resource use and other measures *[New]*
- § 1:328 Feedback reports to PAC providers *[New]*
- § 1:329 Public reporting of PAC performance *[New]*
- § 1:330 Removing, suspending or adding measures *[New]*
- § 1:331 Use of standardized assessment data, quality measures, and resource use and other measures to inform discharge planning and incorporate patient preference *[New]*
- § 1:332 Stakeholder input *[New]*
- § 1:333 Funding input *[New]*
- § 1:334 Limitation *[New]*
- § 1:335 Non-application of Paperwork Reduction Act *[New]*

C. STUDIES FOR ALTERNATIVE PAC PAYMENT MODELS *[New]*

- § 1:336 MEDPAC *[New]*
- § 1:337 Recommendations for PAC prospective payment *[New]*

D. PAYMENT CONSEQUENCES UNDER THE APPLICABLE REPORTING PROVISIONS *[New]*

- § 1:338 Home health agencies *[New]*
- § 1:339 Inpatient rehabilitation facilities *[New]*
- § 1:340 Long-term care hospitals *[New]*
- § 1:341 Skilled nursing facilities *[New]*

E. IMPROVING PAYMENT ACCURACY UNDER THE PAC PAYMENT SYSTEMS AND OTHER MEDICARE PAYMENT SYSTEMS *[New]*

- § 1:342 Studies and reports of effect of certain information on quality and resource use *[New]*
- § 1:343 CMS activities *[New]*
- § 1:344 Strategic plan for accessing race and ethnic data *[New]*

F. HOSPICE CARE *[New]*

- § 1:345 Hospice survey requirement *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 1:346 Technical correction for hospice program recertification
[New]
- § 1:347 Revision to requirement of Medicare review of hospice
care *[New]*
- § 1:348 Update of hospice aggregate payment cap *[New]*

G. MEDICARE IMPROVEMENT FUND *[New]*

- § 1:349 Establishment *[New]*

XX. MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (PUB. L. NO. 114-10) *[New]*

A. OVERVIEW *[New]*

- § 1:350 Medicare Access and CHIP Reauthorization Act of 2015
(Pub. L. No. 114-10) *[New]*

B. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES *[New]*

1. Stabilizing Fee Updates

- § 1:351 Repeal of sustainable growth rate payment methodology;
update of rates for 2015 and subsequent years *[New]*

2. Consolidation of Certain Current Law Performance Programs with New Merit- Based Incentive Payment System

- § 1:352 Electronic health record meaningful use incentive
program; separate quality reporting system and value-
based payment modifier program *[New]*

3. Merit-Based Incentive Payment System (MIPS)

- § 1:353 Establishment—Generally *[New]*
- § 1:354 Establishment—MIPS eligible professional *[New]*
- § 1:355 Establishment—A partial qualifying APM participant
[New]
- § 1:356 Establishment—Group practices *[New]*
- § 1:357 Measures and activities under performance categories
[New]
- § 1:358 Performance standards and periods *[New]*

TABLE OF CONTENTS

- § 1:359 Composite performance score *[New]*
- § 1:360 Clinical practice improvement performance score *[New]*
- § 1:361 Weights for performance categories *[New]*
- § 1:362 Use of voluntary virtual groups for certain assessment purposes *[New]*
- § 1:363 MIPS payments—Generally *[New]*
- § 1:364 MIPS payments—Additional adjustment factors for exceptional performance *[New]*
- § 1:365 MIPS payments—Establishment of performance thresholds *[New]*
- § 1:366 MIPS payments—Application of MIPS adjustment factors; budget neutrality *[New]*
- § 1:367 Announcement of result of adjustment *[New]*
- § 1:368 Public reporting *[New]*
- § 1:369 Consultation with stakeholders *[New]*
- § 1:370 Technical assistance to small practices and practices in health professional shortage areas *[New]*
- § 1:371 Feedback and information to improve performance *[New]*
- § 1:372 Targeted review *[New]*
- § 1:373 GAO reports *[New]*

4. Improving Quality Reporting For Composite Scores

- § 1:374 Clarification of reporting periods; coordination with MIPS *[New]*

5. Promoting Alternative Payment Models

- § 1:375 Physician-focused payment models—Technical advisory committee *[New]*
- § 1:376 Physician-focused payment models—Criteria and process for submission and review of physician-focused payment models *[New]*
- § 1:377 Incentive payments for participation in eligible alternative payment models *[New]*
- § 1:378 Incentive payments for participation in eligible alternative payment models—Qualifying APM participant *[New]*
- § 1:379 Encouraging development and testing of certain models *[New]*
- § 1:380 Construction regarding telehealth services *[New]*
- § 1:381 Integrating Medicare Advantage alternative payment models *[New]*
- § 1:382 Study and report on fraud related to APMs under the Medicare program *[New]*

6. Collaborating With the Physician,
Practitioner, and Other Stakeholder
Communities to Improve Resource Use
Measurement

- § 1:383 In general *[New]*
- § 1:384 Development of care episode and patient condition groups
and classification codes *[New]*
- § 1:385 Attribution of patients to physicians or practitioners
[New]
- § 1:386 Reporting of information for resource use measurement
[New]
- § 1:387 Methodology for resource use analysis *[New]*

7. Priorities and Funding for Measure
Development

- § 1:388 Plan identifying measure development priorities and
timelines *[New]*
- § 1:389 Contracts and other arrangements for quality measure
development *[New]*
- § 1:390 Annual report by the Secretary *[New]*

8. Encouraging Care Management for
Individuals with Chronic Care Needs

- § 1:391 In general; policies related to payment *[New]*
- § 1:392 Education and outreach *[New]*

9. Empowering Beneficiary Choices Through
Continued Access to Information on
Physicians' Services

- § 1:393 In general *[New]*

10. Expanding Availability of Medicare Data

- § 1:394 Expanding uses of Medicare data by qualified entities
[New]
- § 1:395 Access to Medicare data by qualified clinical data
registries to facilitate quality improvement *[New]*
- § 1:396 Expansion of data available to qualified entities *[New]*

11. Reducing Administrative Burden and
Other Provisions

- § 1:397 Medicare physician and practitioner opt-out to private
contract *[New]*
- § 1:398 Promoting interoperability of electronic health records
systems *[New]*

TABLE OF CONTENTS

- § 1:399 GAO studies and reports on the use of telehealth under Federal programs and remote patient monitoring services *[New]*
- § 1:400 Rules of construction regarding health care providers *[New]*

C. MEDICARE AND OTHER HEALTH EXTENDERS *[New]*

1. Medicare Extenders

- § 1:401 Extension of geographic price cost index floor *[New]*
- § 1:402 Extension of therapy cap exceptions process *[New]*
- § 1:403 Extension of ambulance add-ons *[New]*
- § 1:404 Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals *[New]*
- § 1:405 Extension of Medicare-Dependent Hospital (MDH) Program *[New]*
- § 1:406 Extension for specialized Medicare Advantage plans for special needs individuals *[New]*
- § 1:407 Extension for funding for quality measure endorsement, input and selection *[New]*
- § 1:408 Extension for funding outreach and assistance for low-income programs *[New]*
- § 1:409 Extension and transition of reasonable cost reimbursement contracts—One-year transition and notice regarding transition *[New]*
- § 1:410 Extension and transition of reasonable cost reimbursement contracts—Deemed enrollment from reasonable cost reimbursement contracts to Medicare Advantage plans *[New]*
- § 1:411 Extension and transition of reasonable cost reimbursement contracts—Information requirements *[New]*
- § 1:412 Extension and transition of reasonable cost reimbursement contracts—Treatment of transition plan for quality rating for payment purposes *[New]*
- § 1:413 Extension of home health rural add-on *[New]*

2. Other Health Extensions

- § 1:414 Permanent extension of qualifying individual (QI) program *[New]*
- § 1:415 Permanent extension of transitional medical assistance (TMA) *[New]*
- § 1:416 Extension of special diabetes program form type 1 diabetes and for Indians *[New]*
- § 1:417 Extension health workforce demonstration project for low-income individuals *[New]*
- § 1:418 Tennessee DSH allotment for fiscal years 2015 through 2025 *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 1:419 Delay in effective date for Medicaid amendments relating to beneficiary liability settlements *[New]*

D. CHIP *[New]*

- § 1:420 Two year extension of Children’s Health Insurance Program *[New]*
§ 1:421 Extension of express lane eligibility *[New]*
§ 1:422 Extension of outreach and enrollment program *[New]*
§ 1:423 Extension of certain programs and demonstration projects *[New]*
§ 1:424 Report of the Inspector General of HHS on use of express lane option under Medicaid and CHIP *[New]*

E. OFFSETS *[New]*

1. Medicare Beneficiary Reforms

- § 1:425 Limitation for certain Medigap policies for newly eligible Medicare beneficiaries *[New]*
§ 1:426 Income related premium adjustment for Parts B and D *[New]*

2. Other Offsets

- § 1:427 Medicare payment updates for post-acute providers *[New]*
§ 1:428 Delay of reduction to Medicaid DSH allotments *[New]*
§ 1:429 Levy on delinquent providers *[New]*

F. MISCELLANEOUS *[New]*

1. Protecting the Integrity of Medicare

- § 1:430 Prohibition of inclusion of Social Security account numbers on Medicare cards *[New]*
§ 1:431 Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present and deceased individuals *[New]*
§ 1:432 Consideration of measures regarding Medicare beneficiary smart cards *[New]*
§ 1:433 Modifying Medicare durable medical equipment face-to-face encounter documentation requirement *[New]*
§ 1:434 Reducing improper Medicare payments—Medicare administrative contractor improper payment outreach and education program *[New]*
§ 1:435 Reducing improper Medicare payments—Use of certain funds recovered by recovery audit contractors *[New]*
§ 1:436 Improving senior Medicare patrol and fraud reporting rewards *[New]*

TABLE OF CONTENTS

- § 1:437 Requiring valid prescriber national provider identifiers on pharmacy claims *[New]*
- § 1:438 Option to receive Medicare summary note electronically *[New]*
- § 1:439 Renewal of Medicare Administrative Contractor contracts *[New]*
- § 1:440 Study on pathway for incentives to states for state participation in Medicaid data match program *[New]*
- § 1:441 Guidance on application of common rule to clinical data registries *[New]*
- § 1:442 Eliminating certain civil money penalties; gainsharing study and report *[New]*
- § 1:443 Modification of the Medicare home health surety bond condition of participation requirement *[New]*
- § 1:444 Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation—In general *[New]*
- § 1:445 Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation—Improving documentation of services *[New]*
- § 1:446 Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation—GAO study and report *[New]*
- § 1:447 National expansion of prior authorization model for repetitive schedule non-emergent ambulance transport *[New]*
- § 1:448 Repealing duplicative Medicare secondary payor provision *[New]*
- § 1:449 Plan for expanding data in annual Comprehensive Error Rate Testing report *[New]*
- § 1:450 Removing funds for Medicare Improvement Fund added by IMPACT Act of 2014 *[New]*
- § 1:451 Rule of construction *[New]*

2. Other Provisions

- § 1:452 Extension of two-midnight Protecting Access to Medicare Act rules on certain medical review activities *[New]*
- § 1:453 Requiring bid surety bonds and State licensure for entities submitting bids under the Medicare DMEPOS competitive acquisition program *[New]*
- § 1:454 Payment for global surgical packages *[New]*

XXI. BIPARTISAN BUDGET ACT OF 2018 (PUB. L. NO. 115-165) *[New]*

- § 1:455 Modifications to Medicare *[New]*
- § 1:456 Extensions *[New]*

CHAPTER 2. DEFINITIONS, TERMS, AND ACRONYMS

I. DEFINITIONS

- § 2:21 Conversion factor (CF)
- § 2:27 Covered surgical procedures
- § 2:32 Disproportionate share hospitals
- § 2:42 Enrollment periods—Special Enrollment Period
- § 2:43 Extended care services
- § 2:57 Independent laboratory

II. TERMS AND ACRONYMS

- § 2:81 Glossary of Terms
- § 2:82 Glossary of Acronyms

CHAPTER 3. PERSONS ELIGIBLE

II. SPECIFIC CLASSES OF PERSONS ELIGIBLE

- § 3:2 Overview
- § 3:9.50 Legally married same-sex couples *[New]*

CHAPTER 4. PROVIDER OF SERVICES

I. INTRODUCTION

- § 4:4 New provider exempt from routine cost limits (RCL)

II. AGREEMENTS

- § 4:8 Acquisition costs of provider—Disallowance

IV. CERTIFICATION

- § 4:18 Home health services
- § 4:24 Comprehensive outpatient rehabilitation facility services

V. DEPOSIT AND PREPAYMENT REQUESTS

- § 4:26 Effect on private insurance policy of prepayment arrangement

VI. PERMISSIBLE CHARGES

- § 4:31 Retroactive adjustments

TABLE OF CONTENTS

§ 4:32 Legislative changes

VIII. TERMINATION OF PROVIDER PARTICIPATION AGREEMENT

§ 4:43 Termination of provider participation agreement—By CMS

CHAPTER 5. HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND OTHER MANAGED CARE ORGANIZATIONS

II. QUALIFYING CONDITIONS

§ 5:7 Staffing and supervision

III. REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

§ 5:23 Reapplication for qualification

IV. PHYSICIAN AND MANAGED CARE RESTRICTIONS

§ 5:28 Notice requirement in managed care systems

V. MEDICARE PAYMENTS TO HMOS AND CMPS

§ 5:35 Payment for covered services—Generally

VI. ENROLLMENT PROCEDURES

§ 5:38 Overview

VII. LIABILITY OF HMO

§ 5:53 Claim for injunctive or equitable relief

VIII. BENEFICIARY APPEALS

§ 5:55 Overview

§ 5:56 Definitions applicable to beneficiary appeals

§ 5:57 Initial determination (organization determination)

§ 5:58 Notice of adverse initial determination

§ 5:59 Parties to the initial determination

§ 5:60 Effect of initial determination

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 5:61 Right to reconsideration
- § 5:62 Request for reconsideration
- § 5:63 Opportunity to submit evidence during reconsideration
- § 5:64 Responsibility for reconsideration
- § 5:65 Reconsideration determination
- § 5:66 Notice of reconsidered determination
- § 5:67 Effect of reconsidered determination
- § 5:68 Right to a hearing
- § 5:69 Request for hearing
- § 5:71 Departmental Appeals Board (DAB) review
- § 5:72 Reopening determinations and decisions
- § 5:73 Judicial review

IX. MEDICARE CONTRACT APPEALS

- § 5:74 Overview
- § 5:75 Determinations subject to appeal
- § 5:76 Administrative actions that are not initial determinations *[Deleted]*
- § 5:77 Notice of contract determination *[Retitled]*
- § 5:78 Effect of contract determination *[Retitled]*
- § 5:79 Right to request reconsideration *[Deleted]*
- § 5:80 Request for reconsideration *[Deleted]*
- § 5:81 Opportunity to submit evidence during reconsideration *[Deleted]*
- § 5:82 Reconsideration determination *[Deleted]*
- § 5:83 Notice of reconsideration determination *[Deleted]*
- § 5:84 Effect of reconsidered determination *[Deleted]*
- § 5:85 Right to a hearing
- § 5:86 Request for hearing
- § 5:87 Postponement of effective date of contract determination *[Retitled]*
- § 5:88 Designation of hearing officer
- § 5:89 Disqualification of hearing officer
- § 5:90 Authority of hearing officer
- § 5:91 Time and place of hearing
- § 5:92 Appointment of representatives
- § 5:93 Authority of representatives
- § 5:94 Conduct of hearing
- § 5:95 Evidence
- § 5:96 Witnesses
- § 5:97 Discovery *[Deleted]*
- § 5:98 Prehearing conference
- § 5:99 Record of hearing
- § 5:100 Notice and effect of hearing decision
- § 5:100.50 Review by Administrator *[New]*

TABLE OF CONTENTS

- § 5:101 Reopening of contract determination or decision of a hearing officer or Administrator *[Retitled]*
- § 5:102 Effect of revised determination *[Deleted]*

X. IMPACT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT (“ERISA”)

- § 5:104 Preemption of state laws by ERISA

Subpart B. MEDICAL FACILITIES, CARE AND SERVICES

CHAPTER 6. INPATIENT HOSPITAL SERVICES

II. PATIENT “BILL OF RIGHTS” REQUIREMENTS

- § 6:7 Contents of “Bill of Rights” statement—Your Medicare patient rights
- § 6:11 Contents of “Bill of Rights” statement—Your Medicare appeal rights—Appeal rights under Medicare managed care plans
- § 6:12 Peer Review Organization (PRO) review obligation
- § 6:13 Premature discharge from hospital restrictions—Generally

V. SERVICES COVERED IN WHOLE OR IN PART

- § 6:29 Dental services
- § 6:32 Emergency hospital services—Generally
- § 6:33 Emergency hospital services—Emergency Medical Treatment and Active Labor Act (EMTALA)
- § 6:36 Emergency hospital services—Failure to carry out EKG screening
- § 6:37 Emergency hospital services—Need to comply with notice of injury/statute of limitations
- § 6:39 Emergency hospital services—Duty on emergency departments
- § 6:41 Emergency hospital services—Liability of hospital on discharge of stabilized patient
- § 6:42 Emergency hospital services—Denial of punitive damages in medical malpractice case
- § 6:48 Emergency hospital services—Equitable tolling of statute of limitations
- § 6:53 Interns, residents-in-training and teaching physicians

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 6:63 Christian Science sanatorium services and religious nonmedical health care institutions

VI. LIMITATIONS ON COVERAGES

- § 6:65 Inpatient hospital deductible
§ 6:68 Red blood cells and whole blood—Supplemental Medical Insurance program
§ 6:70 Psychologist and physical therapists services—Generally
§ 6:79 Experimental procedures
§ 6:82 Workers' compensation deduction

VII. SPECIFIC LIMITATIONS ON PAYMENTS FOR HOSPITAL CARE

- § 6:88 Employer Group Health Plan coverage (GHP)—Generally
§ 6:90 Large Group Health Plans (LGHPs)
§ 6:92 Payment for outlier services
§ 6:93 Automobile and liability insurance exclusions—Generally

CHAPTER 7. EXTENDED CARE SERVICES

I. GENERAL SKILLED NURSING FACILITY PROVISIONS

- § 7:1 Overview
§ 7:2 Skilled Nursing Facility (SNF) coverage and qualifying criteria
§ 7:3 Basic requirements pertaining to skilled nursing service—Three day hospital stay requirement
§ 7:6 Participating SNF requirements
§ 7:8 Prospective payments

II. CERTIFICATION REQUIREMENTS

- § 7:10 Advanced certification/approval
§ 7:13 Hospice care certification requirements

III. COVERAGES AND LIMITATIONS ON COVERAGES

- § 7:16 Covered services
§ 7:20 Diagnostic and therapeutic items
§ 7:22 Hospice care services—Generally

IV. SPECIFIC LIMITATIONS ON PAYMENT

TABLE OF CONTENTS

FOR SERVICES

- § 7:30 Deductibles and coinsurance
- § 7:33 Automobile liability insurance exclusion

V. EVIDENCE AND PROOF IN SKILLED NURSING CARE CASES

- § 7:37 Overview
- § 7:39 Treating physician's opinion in SNF care cases

CHAPTER 8. HOME HEALTH SERVICES

I. HOME HEALTH SERVICE PROVISIONS

- § 8:4 Certification and approved plan requirements
- § 8:6 Participation requirements

II. HOME HEALTH COVERAGES

- § 8:10 Home health aide services
- § 8:15 Nursing care
- § 8:17 Physical, occupational and speech therapy
- § 8:18 End-stage renal disease—Generally
- § 8:21 End-stage renal disease—Regular course of dialysis regulations

III. PAYMENT METHOD AND LIMITATIONS ON PAYMENTS

- § 8:24 Overview
- § 8:26 Drugs exclusion
- § 8:27 Prospective payment methodology for outpatient hospital services

Subpart C. COVERAGES AND BENEFITS CATEGORIES

CHAPTER 9. ELIGIBILITY

I. BASIC ELIGIBILITY REQUIREMENTS

- § 9:8 “Buy-in” agreements—Qualified medicare beneficiaries/
specified low-income medicare beneficiaries
- § 9:10 Medicare Advantage eligibility provisions
- § 9:11 Kidney dialysis patient eligibility
- § 9:12 Hospice patient eligibility

II. LIMITATIONS AND RESTRICTIONS ON COVERAGES

- § 9:17 Overview
- § 9:18 Alien limitations

CHAPTER 10. ENROLLMENT PROCEDURES

I. GENERAL ENROLLMENT PROVISIONS

- § 10:5.5 Part D enrollment procedures *[New]*
- § 10:6 Disqualifying conditions
- § 10:8 Medicare supplemental insurance policies (Medigap Policies)—Generally
- § 10:12 Medicare supplemental insurance policies (Medigap policies)—Medicare Medigap duplication disclosure requirements
- § 10:15 Medicare supplemental insurance policies (Medigap policies)—Conforming amendments to Medicare Advantage changes
- § 10:16 Medicare supplemental insurance policies (Medigap policies)—High deductible Medigap policies

II. ENROLLMENT PERIODS

- § 10:18 Overview
- § 10:19 Initial period of enrollment
- § 10:23 Medical savings enrollment provisions—Option of health care plans under medicare advantage and medical savings accounts

III. PREMIUMS AND METHODS OF PAYMENTS

- § 10:24 Overview

CHAPTER 11. BENEFIT CATEGORIES

I. SERVICES COVERED UNDER PART A HOSPITAL INSURANCE BENEFITS

- § 11:3 Alcoholism treatments
- § 11:4 Hospice services
- § 11:6 Psychiatric hospital services
- § 11:7 End-stage renal disease coverages

II. SERVICES COVERED UNDER PART B

TABLE OF CONTENTS

SUPPLEMENTARY MEDICAL INSURANCE BENEFITS

- § 11:11 Overview
- § 11:13 Ambulance service—Generally
- § 11:15 Ambulance service—Coverage of air ambulance
- § 11:21 Diagnostic X-ray and/or laboratory tests
- § 11:22 Comprehensive outpatient rehabilitation facility services
- § 11:24 Drugs and biologicals
- § 11:25 Durable medical equipment—Generally
- § 11:26 Durable medical equipment—Customized wheelchair
- § 11:27.50 Joint replacement surgery *[New]*
- § 11:32 Outpatient hospital diagnostic services
- § 11:33 Outpatient physical, occupational and speech pathology therapy services
- § 11:40 Pathologists reimbursement

III. LIMITATIONS ON BENEFITS

- § 11:42 Deductibles and coinsurance—Part B
- § 11:50 Mental illness limitation
- § 11:52 Routine medical care
- § 11:54 Reasonable cost basis

IV. ASSIGNMENTS AND OVERPAYMENTS

- § 11:56 Assignment of claims
- § 11:58 Overpayments—Generally

CHAPTER 12. BALANCED BUDGET ACT OF 1997—MEDICARE

I. MEDICARE+CHOICE (NOW MEDICARE ADVANTAGE) PROGRAM

- § 12:2 Establishment of Medicare+Choice (now Medicare Advantage) program
- § 12:4 Medicare+Choice (now Medicare Advantage) organization

II. MEDIGAP PROTECTIONS

- § 12:9 High deductible Medigap plans

III. DEMONSTRATION PROJECTS

- § 12:10 Coverage under MSA plans on a demonstration basis

IV. PREVENTIVE INITIATIVES/SCREENING

- § 12:24 Vaccines outreach expansion

V. RURAL INITIATIVES

- § 12:26 Medicare rural hospital flexibility program
§ 12:28 Hospital geographic reclassification permitted for purposes of disproportionate share payment adjustments
§ 12:29 Medicare-dependent, small rural hospital payment extension
§ 12:31 Rural health clinic services—Shortage areas
§ 12:32 Medicare reimbursement for telehealth services

VI. ANTI-FRAUD AND ABUSE PROVISIONS AND IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

- § 12:38 Imposition of civil money penalties

VII. IMPROVEMENT IN PROTECTING PROGRAM INTEGRITY

- § 12:43 Advisory opinions regarding certain physician self-referral provisions
§ 12:44 Replacement of reasonable charge methodology by fee schedules
§ 12:45 Application of inherent reasonableness to all part B services other than physicians' services

VIII. PAYMENT FOR PPS EXEMPT HOSPITALS

- § 12:53 Bonus and relief payments
§ 12:55 Treatment of certain long-term care hospitals
§ 12:56 Treatment of certain cancer hospitals
§ 12:58 Prospective payment for outpatient rehabilitation services
§ 12:59 Development of proposal on payments for long-term care hospitals
§ 12:60 Prospective payment for skilled nursing facility services

IX. HOSPICE SERVICES AND RELATED PROVISIONS

- § 12:62 Payments for hospice services
§ 12:68 Extending the period for physician certification of an individual's terminal illness

TABLE OF CONTENTS

X. PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

- § 12:72 Prospective payment for outpatient rehabilitation services

XII. PART B PREMIUMS

- § 12:75 Determination of the amount of part B premium
- § 12:77 Protections under the Medicare program for disabled workers who lose benefits under a group health plan

XIV. GRADUATE MEDICAL EDUCATION PAYMENTS UNDER BBA OF 1997

- § 12:87 Overview

XV. MEDICARE SECONDARY PROVISIONS UNDER BBA OF 1997

- § 12:96 Permanent extension and revision of certain secondary payer provisions

XVI. MISCELLANEOUS PAYMENT PROVISIONS UNDER BBA OF 1997

- § 12:98 Payments for durable medical equipment—Generally
- § 12:102 Oxygen and oxygen equipment
- § 12:103 Reduction in updates to payment amounts for clinical diagnostic laboratory tests

CHAPTER 13. MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

II. MEDICARE PRESCRIPTION DRUG BENEFIT

- § 13:4 Medicare prescription drug benefit
- § 13:4.50 Medicare negotiation of costs of certain prescription drugs *[New]*
- § 13:5 Medicare Advantage conforming amendments
- § 13:6 Medicaid prescription drugs provisions
- § 13:7 Medigap amendments
- § 13:8 Additional drug-related provisions

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 13:8.50 Additional drug-related provisions—Medicare limitations on co-pays; insulin; vaccines; maximum out-of-pocket amounts *[New]*
- § 13:11 Grants to physicians to implement electronic prescription drug program
- § 13:14.5 Fees allowed for supplying and dispensing drugs *[New]*

III. MEDICARE ADVANTAGE

A. IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM

- § 13:15 Implementation of Medicare Advantage (MA) program

D. ADDITIONAL REFORMS

- § 13:23 Reimbursement for federally qualified health centers providing services under MA plans (FQHCs)

IV. COMBATTING WASTE, FRAUD, AND ABUSE

- § 13:26 Durable medical equipment, prosthetics, orthotics, and other supplies (DMEPOS)
- § 13:27 Payment reform for covered outpatient drugs and biologicals

V. RURAL PROVISIONS

C. PROVISIONS RELATING TO PARTS A AND B

- § 13:43 Redistribution of unused resident positions

VI. PROVISIONS RELATING TO PART A

B. OTHER PROVISIONS

- § 13:55 Study of portable diagnostic ultrasound services for beneficiaries in SNFs

VII. PROVISIONS RELATING TO PART B

A. PROVISIONS RELATING TO PHYSICIANS' SERVICES

- § 13:56 Revision of updates for physicians' services

TABLE OF CONTENTS

B. PREVENTATIVE SERVICES

- § 13:60 Coverage of an initial preventive physical examination

C. OTHER PROVISIONS

- § 13:66 Payment for renal dialysis services
§ 13:67 Two-year moratorium or therapy caps
§ 13:68 Waiver of Part B late enrollment penalty for certain military retirees
§ 13:69 Payment for services furnished in ambulatory surgical centers (ASC)

D. ADDITIONAL DEMONSTRATIONS, STUDIES AND OTHER PROVISIONS

- § 13:76 Demonstration of coverage of chiropractic services under Medicare

VIII. PROVISIONS RELATING TO PARTS A AND B

E. INCOME-RELATED REDUCTION IN PART B PREMIUM SUBSIDY

- § 13:88 Income-related reduction in part B premium subsidy

IX. COST CONTAINMENT—INCOME-RELATED REDUCTION IN PART B PREMIUM SUBSIDY

- § 13:90 Payment for durable medical equipment, prosthetics, orthotics, and other supplies (DMEPO)

X. ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION AND CONTRACTING REFORM

E. APPEALS AND RECOVERY

- § 13:103 Transfer of responsibility for medicare appeals
§ 13:105 Revisions of Medicare appeals process
§ 13:107 Recovery of overpayment
§ 13:110 Prior determination process for certain items and services; advance beneficiary notices
§ 13:112 Revisions to appeal timeframes and amounts
§ 13:113.5 Prescription drug administrative procedures *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 13:113.10 Prescription drug administrative procedures—Coverage determinations *[New]*
- § 13:113.15 Prescription drug administrative procedures—Grievances *[New]*
- § 13:113.20 Informal written reconsideration—Sponsor disputes *[New]*
- § 13:113.25 Informal request for hearing—Sponsor dispute *[New]*
- § 13:113.30 Review by administrator—Sponsor dispute *[New]*
- § 13:113.35 Expediting certain coverage determinations *[New]*
- § 13:113.40 Formulary grievance (hearing) procedures *[New]*
- § 13:113.45 Prescription drug hearings conducted by administrative law judges (ALJs) *[New]*
- § 13:113.50 Prescription drug hearings conducted by nonadministrative law judges *[New]*

F. MISCELLANEOUS PROVISIONS

- § 13:125 Other provisions (GAO/OIG reporting requirements)

XI. MEDICAID AND MISCELLANEOUS PROVISIONS

A. MEDICAID PROVISIONS

- § 13:126 Medicaid Disproportionate Share Hospital (DSH) payments
- § 13:127 Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the Medicaid drug rebate program

XII. ACCESS TO AFFORDABLE PHARMACEUTICALS

A. ACCESS TO AFFORDABLE PHARMACEUTICALS

- § 13:133 Thirty-month stay-of-effectiveness period (prescription drugs)
- § 13:134 Substandard coverage/credible drug coverage *[Retitled]*

XIII. PRESCRIPTION DRUG BENEFIT—ADDITIONAL PROVISIONS *[New]*

- § 13:135.5 Alternative prescription drug coverage *[New]*
- § 13:136 Beneficiary with original medicare plan (medicare part A and B without prescription drug coverage) *[New]*

TABLE OF CONTENTS

- § 13:137 Prescription drug coverage from former or current employer or union *[New]*
- § 13:138 Out-of-network access to covered Part D drugs *[New]*
- § 13:139 Fallback prescription drug plan *[New]*
- § 13:140 Medicare Part D subsidy provisions *[New]*
- § 13:141 Public disclosure of pharmaceutical prices for equivalent drugs *[New]*
- § 13:142 Change of ownership of part D prescription drug program *[New]*
- § 13:143 Assuring access to a choice of prescription drug coverage *[New]*

CHAPTER 13A. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 *[New]*

I. INTRODUCTION *[New]*

- § 13A:0.30 Introduction *[New]*
- § 13A:0.40 One Big Beautiful Bill Act; Trump administration proposed ACA changes for 2026 *[Retitled]*

II. QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS *[New]*

A. IMMEDIATE IMPROVEMENTS IN HEALTH CARE COVERAGE *[New]*

- § 13A:0.70 Pre-existing condition health care coverage *[New]*

B. STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS *[New]*

- § 13A:1 State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid *[New]*

C. AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS *[New]*

1. Premium Tax Credits and Cost-Sharing Reductions

- § 13A:2 Refundable tax providing premium assistance for coverage under a qualified health plan *[New]*

2. Reinsurance and Risk Adjustment

- § 13A:3 Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs *[New]*
- § 13A:4 Disclosures to carry out eligibility requirements for certain programs *[New]*

D. RESPONSIBILITY FOR HEALTH CARE *[New]*

- § 13A:5 Requirement to maintain minimum essential coverage *[New]*
- § 13A:6 Shared responsibility for employers *[New]*

III. ROLE OF PUBLIC PROGRAMS *[New]*

A. IMPROVED ACCESS TO MEDICAID *[New]*

- § 13A:7 Medicaid coverage for the lowest income populations *[New]*
- § 13A:8 Income eligibility for non-elderly determined using modified adjusted gross income *[New]*
- § 13A:9 Requirement to offer premium assistance for employer-sponsored insurance *[New]*
- § 13A:10 Medicaid coverage for former foster care children *[New]*
- § 13A:11 Payments to territories *[New]*
- § 13A:12 Special adjustment to FMAP determination for certain States recovering from a major disaster *[New]*
- § 13A:13 Medicaid Improvement Fund rescission *[New]*

B. ENHANCED SUPPORT FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM *[New]*

- § 13A:14 Additional federal financial participation for CHIP *[New]*
- § 13A:15 Technical corrections *[New]*

C. MEDICAID AND CHIP ENROLLMENT SIMPLIFICATION *[New]*

- § 13A:16 Enrollment Simplification and coordination with State Health Insurance Exchanges *[New]*
- § 13A:17 Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligibility populations *[New]*

TABLE OF CONTENTS

D. IMPROVEMENTS TO MEDICAID SERVICES *[New]*

- § 13A:18 Coverage for freestanding birth center services *[New]*
- § 13A:19 Concurrent care for children *[New]*
- § 13A:20 State eligibility option for family planning services *[New]*
- § 13A:21 Clarification of definition of medical assistance *[New]*

E. NEW OPTIONS FOR STATES TO PROVIDE LONG-TERM SERVICES AND SUPPORTS *[New]*

- § 13A:22 Community First Choice Option *[New]*
- § 13A:23 Removal of barriers to providing home community-based services *[New]*
- § 13A:24 Money Follows the Person Rebalancing Demonstration *[New]*
- § 13A:25 Protection for recipients of home and community-based services against spousal impoverishment *[New]*

F. MEDICAID PRESCRIPTION DRUG COVERAGE *[New]*

- § 13A:26 Prescription drug rebates *[New]*
- § 13A:27 Providing adequate pharmacy reimbursement *[New]*

G. MEDICAL DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS *[New]*

- § 13A:28 Disproportionate share hospital payments *[New]*

H. IMPROVED COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES *[New]*

- § 13A:29 Five-year period for demonstration projects *[New]*
- § 13A:30 Providing Federal coverage and payment coordination for dual eligible beneficiaries *[New]*

I. IMPROVING THE QUALITY OF MEDICAID FOR PATIENTS AND PROVIDERS *[New]*

- § 13A:31 Adult health quality measures *[New]*
- § 13A:32 Payment adjustment for health care-acquired conditions *[New]*
- § 13A:33 State option to provide health homes for enrollees with chronic conditions *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 13A:34 Demonstration project to evaluate integrated care around hospitalization *[New]*
- § 13A:35 Medicaid Global Payment System Demonstration Project *[New]*
- § 13A:36 Pediatric Accountable Care Organization Demonstration Project *[New]*
- § 13A:37 Medicaid emergency psychiatric demonstration project *[New]*

J. IMPROVEMENT TO THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION *[New]*

- § 13A:38 MAPAC assessment of policies affecting all Medicaid beneficiaries *[New]*

K. PROTECTIONS FOR AMERICAN INDIANS AND ALASKA NATIVES *[New]*

- § 13A:39 Special rules relating to Indians *[New]*
- § 13A:40 Elimination of sunset for reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics *[New]*

IV. IMPROVING THE QUALITY AND EFFECIENCY OF HEALTH CARE *[New]*

A. TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM *[New]*

1. Linking Payment to Quality Outcomes Under the Medicare Program

- § 13A:41 Hospital value-based purchasing program *[New]*
- § 13A:42 Improvements to the physician quality reporting initiative (PQRI) *[New]*
- § 13A:43 Improvements to the physician feedback program *[New]*
- § 13A:44 Quality reporting for long-term care hospitals, inpatient hospitals, inpatient psychiatric hospitals and hospice programs *[New]*
- § 13A:45 Quality reporting for PPS-exempt cancer hospital *[New]*
- § 13A:46 Plans for value-based purchasing program for skilled nursing facilities and home health agencies *[New]*
- § 13A:47 Value-based payment modifier under the physician fee schedule *[New]*
- § 13A:48 Payment adjustment for conditions acquired in hospitals *[New]*

TABLE OF CONTENTS

2. National Strategy to Improve Health Care Quality

- § 13A:49 National strategy *[New]*
- § 13A:50 Interagency Working Group on Health Care Quality *[New]*
- § 13A:51 Quality measure development *[New]*
- § 13A:52 Quality measurement *[New]*
- § 13A:53 Data collection; public reporting *[New]*

3. Encouraging Development of New Patient Care Models

- § 13A:54 Establishment of Center for Medicare and Medicaid Innovation within CMS *[New]*
- § 13A:55 Medicare shared savings program *[New]*
- § 13A:56 National pilot program on payment bundling *[New]*
- § 13A:57 Independent at home demonstration program *[New]*
- § 13A:58 Hospital readmissions reduction program *[New]*
- § 13A:59 Community-Based Care Transitions Program *[New]*
- § 13A:60 Extension of gainsharing demonstration *[New]*

B. IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS *[New]*

1. Ensuring Beneficiary Access to Physician Care and Other Services

- § 13A:61 Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule *[New]*
- § 13A:62 Extension of exception process for Medicare therapy caps *[New]*
- § 13A:63 Extension of payment for technical component of certain physician pathology services *[New]*
- § 13A:64 Extension of ambulance add-ons *[New]*
- § 13A:65 Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities *[New]*
- § 13A:66 Extension of physician fee schedule mental health add-on *[New]*
- § 13A:67 Permitting physician assistants to order post-hospital extended care services *[New]*
- § 13A:68 Exemption of certain pharmacies from accreditation requirements *[New]*
- § 13A:69 Part B special enrollment period for disabled TRICARE beneficiaries *[New]*
- § 13A:70 Payment for bone density tests *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 13A:71 Treatment of certain complex diagnostic laboratory tests *[New]*
- § 13A:72 Improved access for certified nurse-midwife services *[New]*

2. Rural Protections

- § 13A:73 Extension of outpatient hold harmless provision *[New]*
- § 13A:74 Extension of Medicare reasonable costs payments for certain diagnostic laboratory tests furnished to hospital patients in certain rural areas *[New]*
- § 13A:75 Extension of the Rural Community Hospital Demonstration Program *[New]*
- § 13A:76 Extension of the Medicare-dependent hospital (MDH) program *[New]*
- § 13A:77 Temporary improvements to Medicare inpatient hospital payment adjustment for low-volume hospitals *[New]*
- § 13A:78 Improvements to the demonstration project on community health integration models in certain rural counties *[New]*
- § 13A:79 MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving in Rural Areas *[New]*
- § 13A:80 Technical corrections related to critical access hospital services (CAHs) *[New]*
- § 13A:81 Extension of and revision to Medicare rural hospital flexibility program *[New]*

3. Improving Payment Accuracy

- § 13A:82 Payment adjustments for home health care *[New]*
- § 13A:83 Hospice reform *[New]*
- § 13A:84 Improvement to Medicare disproportionate share hospital (DSH) payments *[New]*
- § 13A:85 Misvalued codes under the physician fee schedule *[New]*
- § 13A:86 Modification of equipment utilization factor for advanced imaging services *[New]*
- § 13A:87 Revision of payment for power-driven wheelchairs *[New]*
- § 13A:88 Hospital wage index improvement *[New]*
- § 13A:89 Treatment of certain cancer hospitals *[New]*
- § 13A:90 Payment for biosimilar biological products *[New]*
- § 13A:91 Medicare hospice concurrent care demonstration program *[New]*
- § 13A:92 Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor *[New]*
- § 13A:93 HHS study on urban Medicare-dependent hospitals *[New]*
- § 13A:94 Protecting home health benefits *[New]*

TABLE OF CONTENTS

C. PROVISIONS RELATING TO PART C [New]

- § 13A:95 Benefit protection and simplification [New]
- § 13A:96 Simplification of annual beneficiary election period
[New]
- § 13A:97 Extension for specialized MA plans for special needs
individuals [New]
- § 13A:98 Extension of reasonable cost contracts [New]
- § 13A:99 Technical correction to MA private fee-for service plans
[New]
- § 13A:100 Making senior housing facility demonstration
permanent [New]
- § 13A:101 Authority to deny plan bids [New]
- § 13A:102 Development of new standards for certain Medigap
plans [New]

D. MEDICARE PART D IMPROVEMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS [New]

- § 13A:103 Medicare coverage gap discount program [New]
- § 13A:104 Improvement in determination of Medicare part D
low-income benchmark premium [New]
- § 13A:105 Voluntary de minimis policy for subsidy-eligible
individuals under prescription drug plans and
MA-PD plans [New]
- § 13A:106 Special rule for widows and widowers regarding
eligibility for low-income assistance [New]
- § 13A:107 Improved information for subsidy-eligible individuals
reassigned to prescription drug plans and MA-PD
Plans [New]
- § 13A:108 Funding outreach and assistance for low-income
programs [New]
- § 13A:109 Improving formulary requirements for prescription
drug plans and MA-PD plans with respect to certain
categories or classes of drugs [New]
- § 13A:110 Reducing part D premium subsidy for high-income
beneficiaries [New]
- § 13A:111 Elimination of cost sharing for certain dual-eligible
individuals [New]
- § 13A:112 Reducing wasteful dispensing of outpatient prescrip-
tion Drugs in long-care facilities under prescription
drug plans and MA-PD plans [New]
- § 13A:113 Improved Medicare prescription drug plan and MA-PD
plan complaint system [New]
- § 13A:114 Uniform Exceptions and Appeals Process for Prescrip-
tion Drug Plans and MA-PD Plans [New]

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 13A:115 Office of the Inspector General studies and reports
[New]
- § 13A:116 Including costs incurred by AIDS drug assistance program and Indian Health Services in providing prescription drugs toward the annual out-of-pocket threshold under part D *[New]*

E. ENSURING MEDICARE SUSTAINABILITY *[New]*

- § 13A:117 Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements *[New]*
- § 13A:118 Temporary payment to the calculation of part B premiums *[New]*
- § 13A:119 Independent Medicare Advisory Board *[New]*

F. HEALTH CARE QUALITY IMPROVEMENTS *[New]*

- § 13A:120 Health care delivery system research; Quality improvement technical assistance *[New]*
- § 13A:121 Establishing community health teams to support the patient-centered medical home *[New]*
- § 13A:122 Medication management services in treatment of chronic disease *[New]*
- § 13A:123 Design and implementation of regionalized systems for emergency care response *[New]*
- § 13A:124 Trauma care centers and service availability *[New]*
- § 13A:125 Program to facilitate shared decision making *[New]*
- § 13A:126 Presentation of prescription drug benefit and risk information *[New]*
- § 13A:127 Demonstration program to integrate quality improvement and patient safety training into clinical education of health professional *[New]*
- § 13A:128 Improving women's health *[New]*
- § 13A:129 Patient navigator program *[New]*

G. PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS *[New]*

- § 13A:130 Protecting and improving guaranteed Medicare benefits *[New]*

V. PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH *[New]*

TABLE OF CONTENTS

A. INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES *[New]*

- § 13A:131 Medicare coverage of annual wellness visit providing a personalized preventative plan *[New]*
- § 13A:132 Removal of barriers to preventive services in Medicare *[New]*
- § 13A:133 Evidence-based coverage of preventive services in Medicare *[New]*
- § 13A:134 Improving access to preventive services for eligible adults in Medicaid *[New]*
- § 13A:135 Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid *[New]*
- § 13A:136 Incentives for prevention of chronic diseases in Medicaid *[New]*

B. CREATING HEALTHIER COMMUNITIES *[New]*

- § 13A:137 Healthy aging, living well; Evaluation of community based prevention and wellness programs for Medicare beneficiaries *[New]*
- § 13A:138 Immunizations *[New]*

C. SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION *[New]*

- § 13A:139 Funding for childhood obesity demonstration project *[New]*

VI. HEALTH CARE WORKFORCE IMPROVEMENTS *[New]*

- § 13A:140 Expanding access to primary care services and general surgery services *[New]*
- § 13A:141 Medicare Federally qualified health center improvements *[New]*
- § 13A:142 Distribution of additional residency positions *[New]*
- § 13A:143 Counting resident time in nonprovider settings *[New]*
- § 13A:144 Rules for counting resident time for didactic and scholarly activities and other activities *[New]*
- § 13A:145 Preservation of resident cap positions from closing hospitals *[New]*
- § 13A:146 Graduate nurse education demonstration *[New]*

VII. TRANSPARENCY AND PROGRAM INTEGRITY *[New]*

A. PHYSICIAN OWNERSHIP AND OTHER

TRANSPARENCY [New]

- § 13A:147 Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals *[New]*
- § 13A:148 Transparency reports and reporting of physician ownership in investment interest *[New]*
- § 13A:149 Disclosure requirements for in-office ancillary services the prohibition on physician self-referral for certain imaging services *[New]*
- § 13A:150 Pharmacy benefit managers transparency requirements *[New]*

B. NURSING HOME TRANSPARENCY AND IMPROVEMENT [New]

1. Improving Transparency of Information

- § 13A:151 Required disclosure of ownership and additional disclosable parties information *[New]*
- § 13A:152 Accountability requirements for skilled nursing facilities and nursing facilities *[New]*
- § 13A:153 Nursing home compare Medicare website *[New]*
- § 13A:154 Reporting of expenditures *[New]*
- § 13A:155 Standardized complaint form *[New]*
- § 13A:156 Ensuring staffing accountability *[New]*

2. Targeting Enforcement

- § 13A:157 Civil money penalties *[New]*
- § 13A:158 National independent monitor demonstration project *[New]*
- § 13A:159 Notification of facility closure *[New]*
- § 13A:160 National demonstration projects on culture change and use of information technology in nursing homes *[New]*

3. Improving Staff Training

- § 13A:161 Dementia and abuse prevention training *[New]*

C. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG TERM CARE FACILITIES AND PROVIDERS [New]

- § 13A:162 Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers *[New]*

D. MEDICARE, MEDICAID, AND CHIP

TABLE OF CONTENTS

PROGRAM INTEGRITY PROVISIONS *[New]*

- § 13A:163 Provider screening and other enrollment requirements under Medicare, Medicaid and CHIP *[New]*
- § 13A:164 Enhanced Medicare and Medicaid program integrity provisions *[New]*
- § 13A:165 Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank *[New]*
- § 13A:166 Maximum period for submission of Medicare claims reduced to not more than 12 months *[New]*
- § 13A:167 Physicians who order items or services required to be Medicare enrolled physicians or eligible professionals *[New]*
- § 13A:168 Requirements for physicians to provide documentation on referrals to programs at high risk of waste and abuse *[New]*
- § 13A:169 Face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare *[New]*
- § 13A:170 Enhance penalties *[New]*
- § 13A:171 Medicare self-referral disclosure protocol *[New]*
- § 13A:172 Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program *[New]*
- § 13A:173 Expansion of the Recovery Audit Contractor (RAC) program *[New]*

E. ADDITIONAL MEDICAID PROGRAM INTEGRITY PROVISIONS *[New]*

- § 13A:174 Termination of provider participation under Medicaid if terminated under Medicare or other state plan *[New]*
- § 13A:175 Medicaid exclusion from participation relating to certain ownership, control and management affiliations *[New]*
- § 13A:176 Billing agents, clearinghouses, or other alternate payees required to register under Medicaid *[New]*
- § 13A:177 Requirement to report expanded set of data elements under MMIS to detect fraud and abuse *[New]*
- § 13A:178 Prohibition on payments to institutions or entities located outside of the United States *[New]*
- § 13A:179 Overpayments *[New]*
- § 13A:180 Mandatory State use of National Correct Coding Initiative *[New]*

VIII. STRENGTHENING QUALITY,

AFFORDABLE HEALTH CARE FOR ALL AMERICANS [New]

A. PROVISIONS RELATING TO TITLE II [New]

- § 13A:181 Incentives for States to offer home and community based Services as a long-term care alternative to nursing homes [New]

B. PROVISIONS RELATING TO TITLE III [New]

- § 13A:182 Medicare coverage for individuals exposed to environmental health hazards [New]
§ 13A:183 Protections for frontier States [New]
§ 13A:184 Revision to skilled nursing facility prospective payment system [New]
§ 13A:185 Pilot testing pay-for-performance programs for certain Medicare providers [New]
§ 13A:186 Improvement in the part D medication therapy management (MTM) programs [New]
§ 13A:187 Developing methodology to assess health plan value [New]
§ 13A:188 Modernizing computers and data systems of the Centers for Medicare and Medicaid Services to support improvements in care delivery [New]
§ 13A:189 Public reporting of performance information [New]
§ 13A:190 Availability of Medicare data for performance measurement [New]
§ 13A:191 Community-based collaborative care networks [New]
§ 13A:192 GAO study and report on Medicare beneficiary access to high-quality dialysis services [New]

IX. ADDITIONAL HCERA PROVISIONS [New]

A. COVERAGE [New]

- § 13A:193 Income definitions [New]
§ 13A:194 Implementation funding [New]

B. MEDICARE [New]

- § 13A:195 Closing the Medicare prescription drug “donut hole” [New]
§ 13A:196 Medicare Advantage payments [New]
§ 13A:197 Savings from limits on MA plan administrative costs [New]

TABLE OF CONTENTS

§ 13A:198 Payment for qualifying hospitals *[New]*

C. MEDICAID *[New]*

§ 13A:199 Payments to primary care physicians *[New]*

D. REDUCING FRAUD, WASTE AND ABUSE *[New]*

§ 13A:200 Community mental health centers *[New]*

§ 13A:201 Medicare prepayment medical review limitations *[New]*

§ 13A:202 Funding to fight fraud waste and abuse *[New]*

§ 13A:203 90 day period of enhanced oversight for initial DME supplies *[New]*

E. PROVISIONS RELATING TO REVENUE *[New]*

§ 13A:204 High-cost plan excise tax *[New]*

§ 13A:205 Unearned income Medicare contribution *[New]*

§ 13A:206 Delay of the limitations on health flexible spending arrangements under cafeteria plans *[New]*

§ 13A:207 Brand name pharmaceuticals *[New]*

Subpart D. ADMINISTRATIVE PROCEDURES

CHAPTER 14. PRELIMINARY ADMINISTRATIVE PROCEDURES

I. CLAIM PROCEDURES

§ 14:1 Overview

§ 14:2 Part A claims

§ 14:3 Part B claims

§ 14:4 Time limitations

§ 14:4.10 Quality Improvement Organizations (QIO) *[New]*

§ 14:4.20 Program abuse appeals *[New]*

§ 14:4.30 Penalty hearing provisions *[New]*

§ 14:4.40 National Coverage Determination (NCD)/Local Coverage Determination (LCD) *[New]*

II. INITIAL DETERMINATION

§ 14:5 Overview

§ 14:6 Part A claims

§ 14:7 Part B claims

III. REDETERMINATION *[New]*

- § 14:7.10 Overview *[New]*
- § 14:7.15 Right to reconsideration *[New]*
- § 14:7.20 Request for redetermination *[New]*
- § 14:7.25 Evidence in redetermination *[New]*
- § 14:7.30 Conduct of a redetermination *[New]*
- § 14:7.35 Late request for reconsideration *[New]*
- § 14:7.40 Withdrawal of a request for a redetermination *[New]*
- § 14:7.45 Dismissal of a request for a redetermination *[New]*
- § 14:7.50 Consolidation of requests *[New]*
- § 14:7.55 Decision in redetermination proceedings *[New]*
- § 14:7.60 Effect of decision in redetermination proceedings *[New]*

IV. RECONSIDERATION DETERMINATION

- § 14:8 Overview
- § 14:9 Right to reconsideration
- § 14:10 Utilization Review Committee's role in reconsideration procedures
- § 14:11 Request for reconsideration
- § 14:12 Parties to reconsideration determination
- § 14:13 Evidence in reconsideration proceedings
- § 14:13.30 Conduct of a reconsideration *[New]*
- § 14:13.70 Authority of Qualified Independent Contractor *[New]*
- § 14:14 Late request for reconsideration
- § 14:14.30 Withdrawal of a request for a reconsideration *[New]*
- § 14:14.50 Dismissal of a request for reconsideration *[New]*
- § 14:14.70 Consolidation of request *[New]*
- § 14:15 Decision in reconsideration proceedings
- § 14:16 Effect of decision in reconsideration proceedings

**IV RECONSIDERATION
DETERMINATION—PART B**

**V. RE-OPENINGS OF INITIAL
DETERMINATIONS,
REDETERMINATIONS,
RECONSIDERATIONS, HEARINGS AND
REVIEWS *[New]***

- § 14:26.10 Overview *[New]*
- § 14:26.20 Initiation of a reopening *[New]*
- § 14:26.30 Time frame for a reopening *[New]*

TABLE OF CONTENTS

§ 14:26.40 Good cause *[New]*

§ 14:26.50 Notice of a revised determination or decision *[New]*

§ 14:26.60 Effect of a revised determination or decision *[New]*

VI. MANAGED CARE DETERMINATIONS

§ 14:27 Overview

§ 14:30 Medicare Advantage plans—Non-expedited appeals requirements

VII. PROVIDER DETERMINATIONS

Table of Contents

PART I. MEDICARE (CONTINUED)

Subpart D. ADMINISTRATIVE PROCEDURES (CONTINUED)

CHAPTER 15. ADMINISTRATIVE HEARINGS FOR PART A AND PART B BENEFITS

I. GENERAL PROVISIONS

- § 15:1 Overview
- § 15:2 Prohibition against provider representation
- § 15:3 Program abuse appeals

II. LIMITATIONS ON LIABILITY WHERE CLAIMS ARE DENIED (WAIVER PROVISIONS)

- § 15:4 Overview
- § 15:5 Waiver provisions for beneficiary
- § 15:6 Provider's waiver provisions
- § 15:7 Physician/supplier waiver of liability provisions
- § 15:8 Erroneous transfer to lower level of care waiver provisions

III. AMOUNT AND/OR ENTITLEMENT TO BENEFITS

- § 15:9 Overview
- § 15:10 Jurisdictional amount
- § 15:11 Aggregation of claims to meet amount in controversy

IV. HEARING RIGHTS AND HEARING REQUIREMENTS

- § 15:12 Right to hearing
- § 15:13 Request for hearing
- § 15:14 Time and place of hearing

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 15:15 Waiver of hearing
- § 15:16 Submission of written evidence before hearing

V. DISMISSAL OF REQUEST FOR HEARING

- § 15:17 Party requesting
- § 15:18 Amount of benefits
- § 15:19 Abandonment
- § 15:20 Cause
- § 15:21 Failure to appear
- § 15:22 Death of beneficiary
- § 15:23 Res judicata
- § 15:24 Late filing
- § 15:25 Vacation of dismissal
- § 15:25.50 Remands of requests for hearing and requests for review

VI. ADMINISTRATIVE LAW JUDGE AND HEARING PROCEDURES

- § 15:26 Overview
- § 15:27 General powers of an ALJ
- § 15:28 Disqualification of ALJ
- § 15:29 Timeframe for the ALJ to decide the appeal
- § 15:30 Incorporation of certain Title II procedures
- § 15:31 Discovery
- § 15:32 Compulsory process
- § 15:33 Contempt
- § 15:34 Self-incrimination
- § 15:35 Examination of witnesses
- § 15:36 Conduct of a hearing
- § 15:37 Presentation of evidence and proof
- § 15:38 Oral argument and/or written allegations
- § 15:39 Joint hearing
- § 15:40 Record of hearing
- § 15:41 Decision of ALJ
- § 15:42 Binding effect of the ALJ's decision
- § 15:43 On the record decisions

VII. MEDICARE APPEALS COUNCIL REVIEW

- § 15:44 Overview
- § 15:45 Right to review of decision rendered by ALJ
- § 15:46 Time limitation to request review
- § 15:47 Review on own motion
- § 15:48 Scope of review and timeframe for adjudication
- § 15:49 Evidence submitted in review proceeding
- § 15:50 Briefs and written statements

TABLE OF CONTENTS

- § 15:51 Oral argument
- § 15:52 Decision of Council
- § 15:53 Effect of Council's decision
- § 15:54 Judicial review of Council's decision

VIII. ATTORNEY REPRESENTATION AND FEES

- § 15:55 Overview
- § 15:56 Authority of representative
- § 15:57 Fees for services of representative
- § 15:58 Proceedings before the Secretary

IX. APPEALS OF CARRIER DECISIONS THAT SUPPLIER STANDARDS ARE NOT MET

- § 15:59 Overview
- § 15:60 Disallowance of entity's request for billing number
- § 15:61 Appeal to ALJ in billing number dispute
- § 15:62 Nonpayment based on absence of valid billing number
- § 15:63 Reinstatement of billing number

CHAPTER 16.

CHAPTER 17. ADMINISTRATIVE HEARINGS FOR PROVIDER OF SERVICES

I. GENERAL HEARING PROCEDURES

- § 17:2 Overview
- § 17:8 Intermediary hearing procedures—Evidence

III. PRE-HEARING CONFERENCE

- § 17:19 Effect of pre-hearing conference

IV. HEARING PROCEDURES AND PROCEEDINGS

- § 17:23 Withholding payment during fraud investigation
- § 17:25 Pre-hearing suspension of a physician from Medicare program
- § 17:34 Intermediary decision

V. PROVIDER REIMBURSEMENT REVIEW

BOARD PROCEEDINGS

- § 17:38 Overview
- § 17:39 Request for Board hearing
- § 17:43 Conduct of Board hearing
- § 17:47 Other review

Subpart E. JUDICIAL REVIEW

CHAPTER 18. COMMENCING JUDICIAL REVIEW

I. GENERAL JUDICIAL REVIEW PROVISIONS

- § 18:1 Overview
- § 18:2 Statutory provisions authorizing judicial review—
Individuals
- § 18:4 Right to judicial review under Part A
- § 18:5 Right to judicial review under part B
- § 18:6 Right to judicial review of HMO enrollee
- § 18:7 Right to judicial review of Medicare Advantage enrollee
- § 18:8 Judicial review in PRO disputes
- § 18:9 Judicial review of Provider Reimbursement Review Board decisions
- § 18:11 Judicial review of validity of regulations
- § 18:14 Judicial review under the Administrative Procedure Act
- § 18:15 Non-statutory judicial review procedures
- § 18:17 Mandamus-based judicial review
- § 18:18 Exclusiveness of remedy

II. JURISDICTION IN JUDICIAL REVIEW CASES

- § 18:24 Jurisdiction in assignment of benefit cases
- § 18:29 New development in judicial review jurisdiction

III. EXHAUSTION OF ADMINISTRATIVE REMEDIES

- § 18:33 Important case law on exhausting administrative remedy

IV. TIME, VENUE AND PARTIES TO JUDICIAL REVIEW

- § 18:36 Time for commencing action

TABLE OF CONTENTS

- § 18:38 Venue
- § 18:39.50 Parties to judicial review (Caption Form)—Standing issues; establishing “injury in fact” *[New]*

VI. IN FORMA PAUPERIS PROCEEDINGS

- § 18:44 Overview

CHAPTER 19. JUDICIAL REVIEW PROCEDURES

II. MOTION TO DISMISS

- § 19:5 Motion to dismiss (Form)

III. SUMMARY JUDGMENT MOTION

- § 19:6 Statutory provisions
- § 19:9 Burden of proof

IV. SCOPE OF REVIEW

- § 19:11 Evaluation of the evidence
- § 19:13 Examination of record
- § 19:14 Questions of law
- § 19:15 Substantial evidence rule

VI. MISCELLANEOUS JUDICIAL REVIEW PROCEDURES

- § 19:23 Default judgment
- § 19:28 State law preemption cases
- § 19:31 Judicial review in dental care dispute

CHAPTER 20. REMAND

I. GENERALLY

- § 20:3 Proper remand procedures
- § 20:4 Procedure on remand

II. “GOOD CAUSE” FOR REMAND

- § 20:7 Secretary’s request for remand

III. OTHER BASES FOR REMAND

- § 20:15 Mental disability as basis for remand

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 20:18 Application of the administrative procedure act in
Medicare judicial review proceedings

CHAPTER 21. ATTORNEY REPRESENTATION AND FEES

I. REPRESENTATION BY ATTORNEY OR REPRESENTATIVE

- § 21:4 Assessment of user fee for deduction and payment of
attorney's fees (Title II)

II. ATTORNEY'S FEE LIMITATIONS

- § 21:8 CMS's uncertainty about fixing attorney's fees in medicare
cases

PART II. MEDICAID

CHAPTER 22. INTRODUCTION

I. GENERAL INFORMATION ABOUT THE MEDICAID PROGRAM

- § 22:1 Overview
§ 22:2 Deference to agency interpretation of the law
§ 22:3 Freedom of choice provisions
§ 22:4 Assignment to Health Maintenance Organization
(HMO)
§ 22:6 Nonemergency medical transportation
§ 22:11.50 Work requirements *[New]*

II. WHERE TO FIND THE LAW

- § 22:15.50 Medicaid changes contained in One Big Beautiful Bill
Act of 2025 (OBBBA) *[Retitled]*

III. COVERAGES AND ELIGIBILITY

- § 22:16 Overview
§ 22:16.20 Eligibility and eligibility redeterminations—Work
requirements *[New]*
§ 22:17 Statutory provisions

IV. STATE GOVERNMENTAL IMMUNITY

- § 22:22 Overview

TABLE OF CONTENTS

V. WAIVERS

- § 22:25 Overview
- § 22:26 General requirements
- § 22:28 Home and community care based waivers

VI. SUMMARY OF IMPORTANT MEDICAID PROVISIONS

- § 22:31 State share
- § 22:36 Early and periodic screening, diagnosis and treatment program
- § 22:39 Long-term care facility services and inpatient hospital services payments
- § 22:40 Deeming of income between spouses
- § 22:41 Eligibility verification
- § 22:42 Interest on disputed claims

VII. ADDITIONAL MEDICAID PROVISIONS

- § 22:47 Termination of benefits
- § 22:50 Medicaid secondary payer provisions
- § 22:51 Uninsured/low income children

VIII. CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 *[New]*

A. OVERVIEW *[New]*

- § 22:53 Overview *[New]*

B. FUNDING *[New]*

- § 22:54 Extension of CHIP *[New]*
- § 22:55 Allotments for states and territories for fiscal years 2009 through 2013 *[New]*
- § 22:56 Child Enrollment Contingency Fund *[New]*
- § 22:57 CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts *[New]*
- § 22:58 Two-year initial availability of CHIP allotments *[New]*
- § 22:59 Redistribution of unused allotments *[New]*
- § 22:60 Option for qualifying states to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children *[New]*
- § 22:61 One-time appropriation *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 22:62 Improving funding for the territories under CHIP and Medicaid *[New]*

C. FOCUS ON LOW-INCOME CHILDREN AND PREGNANT WOMEN *[New]*

- § 22:63 Focus on low-income children and pregnant women *[New]*
§ 22:64 Phase-out of coverage for nonpregnant childless adults under CHIP; conditions or coverage of parents *[New]*
§ 22:65 Eliminations of counting Medicaid child presumptive eligibility costs against title XXI allotment *[New]*
§ 22:66 Limitation on matching rate for states that propose to cover children with effective family income that exceeds 300 percent of the poverty line *[New]*
§ 22:67 State authority under Medicaid *[New]*

D. OUTREACH AND ENROLLMENT ACTIVITIES *[New]*

- § 22:68 Grants and enhanced administrative funding for outreach and enrollment *[New]*
§ 22:69 Increased outreach and enrollment of Indians *[New]*
§ 22:70 State option to rely on findings from an Express Lane agency to conduct simplified eligibility determinations *[New]*

E. REDUCING BARRIERS TO ENROLLMENT *[New]*

- § 22:71 Verification of declarations of citizenship or nationally for purposes of eligibility for Medicaid and CHIP *[New]*
§ 22:72 Reducing administrative barriers to enrollment *[New]*
§ 22:73 Model of interstate coordinated enrollment and coverage process *[New]*
§ 22:74 Permitting states to ensure coverage without a five-year delay of certain children and pregnant women under the Medicaid program and CHIP *[New]*

F. ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE *[New]*

- § 22:75 Additional state option for providing premium assistance *[New]*
§ 22:76 Outreach, education, and enrollment assistance *[New]*

G. COORDINATING PREMIUM ASSISTANCE WITH PRIVATE

TABLE OF CONTENTS

COVERAGE *[New]*

- § 22:77 Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage, coordination of coverage *[New]*

H. STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES *[New]*

- § 22:78 Child health quality improvement activities for children enrolled in Medicaid or CHIP *[New]*
- § 22:79 Improved availability of public information regarding enrollment of children to CHIP and Medicaid *[New]*
- § 22:80 Application of certain managed care quality safeguards to CHIP *[New]*

I. IMPROVING ACCESS TO BENEFITS *[New]*

- § 22:81 Dental benefits *[New]*
- § 22:82 Mental health parity on CHIP plans *[New]*
- § 22:83 Applications of prospective payment system for services provided by federally-qualified health centers and rural health clinics *[New]*
- § 22:84 Premium grace period *[New]*
- § 22:85 Clarification of coverage of services provided through school-based health centers *[New]*
- § 22:86 Medicaid and CHIP payment and access commission *[New]*

J. PROGRAM INTEGRITY AND DATA COLLECTION *[New]*

- § 22:87 Payment error rate measurement (PERM) *[New]*
- § 22:88 Improving data collection *[New]*
- § 22:89 Updated federal evaluation of CHIP *[New]*
- § 22:90 Access to records for HG and GAO audits and evaluations *[New]*
- § 22:91 No federal funding for illegal aliens; disallowance for unauthorized expenditures *[New]*

K. MISCELLANEOUS HEALTH PROVISIONS *[New]*

- § 22:92 Deficit Reduction Act technical corrections *[New]*
- § 22:93 References to title XXI *[New]*
- § 22:94 Prohibiting initiation of new health opportunity account demonstration programs *[New]*

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 22:95 Adjustment in computation of Medicaid FMAP to disregard in extraordinary employer pension contribution *[New]*
- § 22:96 Clarification treatment of regional medical center *[New]*
- § 22:97 Extension of Medicaid DSH allotments for Tennessee and Hawaii *[New]*

L. OTHER PROVISIONS *[New]*

- § 22:98 Outreach regarding health insurance options available to children *[New]*

CHAPTER 23. DEFINITIONS

I. INTRODUCTION

- § 23:2 Estate

II. HEALTH CARE FACILITIES

- § 23:3 Nursing home

III. SKILLED NURSING FACILITY

- § 23:7 Facility
- § 23:8 Criteria for skilled nursing facility and services

V. PHYSICIAN AND OTHER HEALTH CARE SERVICES

- § 23:14 Dental services
- § 23:15 Home or community-based services
- § 23:17 Physical therapy and related services
- § 23:18 Prescribed drugs
- § 23:20 Prosthetic devices
- § 23:21 Eyeglasses
- § 23:25 Chiropractors' services
- § 23:30 Preventive services

CHAPTER 24. GENERAL PROVISIONS

II. GENERAL ADMINISTRATIVE REQUIREMENTS

- § 24:11 Free choice of providers
- § 24:13 Assurance of transportation
- § 24:15 Waiver of other Medicaid requirements

TABLE OF CONTENTS

IV. AMOUNT AND DURATION OF CARE

- § 24:35 Overview
- § 24:36 Required services for the categorically needy

V. ELIGIBILITY/CITIZENSHIP/ALIENAGE

- § 24:40 Overview
- § 24:40.50 Medicaid changes contained in the One Big Beautiful Bill Act of 2025 (OBBBA) *[Retitled]*
- § 24:41 Residence requirement—Generally
- § 24:43.50 Dual eligible standards *[New]*
- § 24:44 Restrictions on aliens—Generally

VII. MANDATORY COVERAGES

- § 24:50 Overview
- § 24:52 Aid to Families with Dependent Children (AFDC)—Generally
- § 24:53 Aid to Families with Dependent Children (AFDC)—Duty to supply eligibility information
- § 24:54 Supplemental Security Income recipients (SSI)—Generally

VIII. OPTIONAL COVERAGE OF THE MEDICALLY NEEDY

- § 24:59 Overview
- § 24:62 Medically needy coverage—Caretaker relatives

IX. ABORTIONS

- § 24:70 Overview
- § 24:80 Nebraska anti-abortion law

X. STERILIZATIONS

- § 24:89 Informed consent—Consent form requirements

XI. MISCELLANEOUS PROVISIONS

- § 24:92 Overview
- § 24:95 Augmentative communication (speech) device
- § 24:96 Organ transplants—Generally
- § 24:101 Medicaid payment of premiums under group health plans
- § 24:102 Reimbursement for prescription drugs
- § 24:105 Gender-affirming care *[New]*

CHAPTER 25. STATE PLAN REQUIREMENTS

I. GENERAL STATE PLAN REQUIREMENT PROVISIONS

- § 25:1 Overview
- § 25:2 Level of state financial participation—Generally
- § 25:5 Level of state financial participation—State permitted to
tax gross receipts of health care providers
- § 25:8 Single state agency requirement
- § 25:13 Assistance in applying for benefits
- § 25:15 Level and duration of assistance—Generally
- § 25:16 Level and duration of assistance—Freeze on Medicaid
benefits
- § 25:17 Level and duration of assistance—Assuring medicaid
coverage for low-income families
- § 25:18 Administrative and supervision requirements
- § 25:20 Inpatient and outpatient care
- § 25:24 Mental institution inmates provisions—Generally
- § 25:31 Physician's payment plan

II. FAIR HEARING REQUIREMENTS

- § 25:40 Notice to claimant of adverse action(s)
- § 25:44 Decision of hearing official

III. ELIGIBILITY PROVISIONS

- § 25:46.50 Overview *[New]*
- § 25:47 Home and community-based services for the elderly
- § 25:49 Indigent Medicaid-eligible persons
- § 25:50 Restrictive state criteria
- § 25:52 Pregnant woman, specified children, adoptive/foster
children, disabled widower(s), disabled children

IV. SKILLED NURSING FACILITY IN THE MEDICAID PROGRAM

- § 25:64 Nursing home requirements

V. RECOUPMENT PRACTICES

- § 25:65 Overview

VI. THIRD PARTY LIABILITY

- § 25:70 State plan requirements in third party liability claims

TABLE OF CONTENTS

VII. SPEND DOWN RULES

§ 25:78 Overview

VIII. QUALITY OF CARE STANDARDS

§ 25:88 Corrective action under the claims processing assessment systems

X. MISCELLANEOUS STATE PLAN REQUIREMENTS

§ 25:97 Spousal Medicaid deeming regulations (*Gray Panthers* case)

§ 25:99 Sex reassignment surgery

CHAPTER 26. BALANCED BUDGET ACT OF 1997—MEDICAID

I. MANAGED CARE AS AFFECTED BY THE BBA OF 1997

§ 26:4 Quality assurance standards

II. FLEXIBILITY IN PAYMENT TO PROVIDERS

§ 26:12 Flexibility in payment methods for hospital, nursing facility, ICF/MR, and home health services

§ 26:14 Medicaid payment rates for certain Medicare cost-sharing

§ 26:15 Treatment of veterans pensions under Medicaid

III. ELIGIBILITY CHANGES MADE BY BBA OF 1997

§ 26:18 State option to permit workers with disabilities to buy into Medicaid

IV. PROGRAMS OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

§ 26:22 Overview

V. STATE CHILDREN'S HEALTH INSURANCE PROGRAM UNDER BBA OF 1997

§ 26:25 Overview

§ 26:28 Payments to states—FMAP and SCHIP

§ 26:32 Medicaid presumptive eligibility for low-income children

CHAPTER 27. TRUSTS AND TRANSFERS OF ASSETS

- § 27:1 Overview
- § 27:3 Discretionary trust—Generally
- § 27:6 Irrevocable trust
- § 27:7 Inter vivos trust
- § 27:8 Special needs trust—Generally
- § 27:10 Supplemental needs trust—Generally
- § 27:13 Medicaid Qualifying Trust (MQT) (formerly Miller Trust)—Generally
- § 27:18 Transfer of assets for less than market value—Generally

CHAPTER 28. LIENS/ASSETS/ESTATE PLANNING/THIRD PARTY LIABILITY

I. IMPOSITION OF LIEN AGAINST PROPERTY ON ACCOUNT OF MEDICAL ASSISTANCE RENDERED UNDER STATE MEDICAID PLAN

- § 28:2 Definition of property subject to lien
- § 28:4 Restrictions on the placing of liens

II. MEDICAID-TYPE ESTATE PLANNING

- § 28:9 Estate of settler
- § 28:12 Income-producing assets

III. EXEMPT ASSETS

- § 28:17 Community spouse resources allowance (CSRA)—Generally
- § 28:18 Community Spouse Resources Allowance (CSRA)—Increasing community spouse resources
- § 28:22 Principal residence of married persons
- § 28:25 Fixed annuities

IV. THIRD PARTY LIABILITY

- § 28:26 Overview
- § 28:32 Personal injury settlement
- § 28:34 Assessment of attorney's fees against county, state and federal defendants

TABLE OF CONTENTS

CHAPTER 29. PENALTIES AND SANCTIONS

I. GENERAL PROGRAM VIOLATIONS AND SANCTIONS

- § 29:1 Overview
- § 29:3 Termination or adjustment of benefits for program violations
- § 29:4 False Claims Act violations
- § 29:8 Criminal kickbacks, bribes or rebating
- § 29:9 False statements and/or failure to disclose

II. PROGRAM ABUSES

- § 29:10 Overview
- § 29:11 Withholding payment during fraud investigation
- § 29:12 Double assessment based on fraud
- § 29:15 Retroactive application of Civil Monetary Penalty Law
- § 29:16.5 Violation of Health Care Quality Improvement Act (HCQIA) *[New]*

III. CRIMINAL CONVICTIONS

- § 29:18 Nolo contendere plea suspensions
- § 29:23 Submission of false claims conviction

IV. OVERPAYMENT/PENALTY DISPUTES

- § 29:27 Recoupment procedures

CHAPTER 30. FAIR HEARING REQUIREMENTS

I. GENERAL FAIR HEARING PROCEDURES

- § 30:1 Overview
- § 30:2 Hearings for providers
- § 30:3 State unpublished regulations
- § 30:4 Rule adoption procedures
- § 30:5 Impartial triers of the facts
- § 30:7 Pre-termination hearing—Pre-hearing suspension of physician's medicaid practice privilege
- § 30:9 Fair hearing requirements—Generally
- § 30:11 Due Process requirements

II. ADMINISTRATIVE FAIR HEARING

- § 30:12 Right to representation at hearing

MEDICARE AND MEDICAID CLAIMS AND PROCEDURES

- § 30:21 Evidence at hearing—Generally
- § 30:25 Decision of hearing officer
- § 30:26 Notice of decision

III. POST-DECISION PROCEEDINGS

- § 30:29 Appeal rights

CHAPTER 31. JUDICIAL REVIEW

I. FEDERAL COURT JURISDICTION

- § 31:1 Overview
- § 31:2 Application of abstention doctrine under *Burford* case
- § 31:5 Section 1983 (42 U.S.C.A. § 1983) proceedings

II. BASIS PREREQUISITES TO OBTAINING JUDICIAL REVIEW

- § 31:11 Exhausting administrative remedies—Generally
- § 31:17 Justiciability requirement
- § 31:17.50 Justiciability requirement—Final orders only [*New*]

III. SPECIFIC SECTION 1983 (42 U.S.C.A. § 1983) PROCEEDINGS

- § 31:18 Overview
- § 31:19 Waiver and waiver program dispute
- § 31:20 Intermediate care facility/mentally retarded litigation
- § 31:22 Reduction in reimbursement rates

IV. INJUNCTIONS

- § 31:24 Reduction in reimbursement rates

V. GENERAL COURT ACTIONS OR JUDICIAL REVIEW PROCEEDINGS

- § 31:26 Declaratory judgment

VI. MISCELLANEOUS COURT JUDICIAL REVIEW PROCEEDINGS

- § 31:35 Remand by the court
- § 31:37 Civil rights violations
- § 31:41 Untimeliness; limitations of actions [*New*]

APPENDICES

TABLE OF CONTENTS

Appendix B. List of Medicare Administrative
Contractors *[Retitled]*

Appendix C. List of Medicare Carriers *[Deleted]*

Appendix D. List of Medicare Beneficiary and Family Centered
Care Quality Improvement Organizations *[Retitled]*

Appendix E. List of State Medical Assistance Contacts

Table of Laws and Rules

Table of Cases

Index