

(1) Payment to CMS must be received by CMS by the first day of each month.

(2) There is a 10-day grace period for receipt of payment.

(3) Payment must be made to CMS via electronic funds transfer.

(c) *Late payment penalties.* CMS may assess interest for any payment it does not receive by the first day of the month as follows:

(1) Interest will be assessed at the SMI trust fund rate as computed for new investments in accordance with section 1841(c) of the Act.

(2) Interest will be waived if the full payment is received by the 10th day of the month in which it is due.

(3) Interest will be calculated and assessed in 30-day increments.

(4) Interest will be assessed on the balance of the amount billed that remains unpaid at the expiration of the grace period and unpaid balances from prior periods.

(5) Interest will continue to accrue on unpaid amounts until the balance is paid in full.

(d) *Disagreement over billing amounts or interest.* If the State or local government agency disagrees with the amount assessed in a billing statement or interest charge, it must notify CMS as follows:

(1) The State or local government agency must provide evidence suitable to CMS to substantiate its claim.

(2) The State or local government agency must continue to make full payment while CMS evaluates the evidence provided.

(3) Credit for payment amounts or interest that CMS determines to be due to the State or local government agency will be reflected as an adjustment in subsequent bills, effective on the date the corrected amount would have been due.

§ 408.210 Termination of SMI premium surcharge agreement.

(a) *Termination by the State or local government agency.* The State or local government agency may voluntarily terminate its agreement with CMS as follows:

(1) The State or local government agency must notify CMS, in writing, at least 30 days before the effective date of the termination.

(2) The State or local government agency must pay any unpaid premium surcharge amounts and interest due within 30 days after the effective date of the termination.

(3) Interest will continue to accrue until all amounts due are paid in full.

(b) *Termination by CMS.* CMS may terminate the agreement with a State or local government agency as follows:

(1) If a State or local government agency's payments are delinquent 30 days or more, CMS may terminate the agreement with 30 days advance notice.

(2) If the State or local government agency fails to comply with the terms of the agreement or procedures promulgated by CMS, CMS may terminate the agreement with 30 days advance notice.

(3) If CMS finds that the State or local government agency is not acting in the best interest of the enrollees, or CMS, or for any reason other than those in paragraphs (b)(1) and (b)(2) of this section, CMS may terminate the agreement at any time.

(4) The State or local government agency must pay all outstanding premium surcharge and any interest amounts due within 30 days after the effective date of the termination.

(5) Interest will continue to accrue until all amounts due are paid in full.

(6) After the agreement is terminated, CMS will resume collection of the premium surcharge from the enrollees covered under the terminated agreement.

(7) If an agreement is terminated by CMS, the State or local government agency must wait 3 years from the effective date of the termination before it can request to enter into another SMI premium surcharge agreement.

PART 409—HOSPITAL INSURANCE BENEFITS

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AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 48 FR 12541, Mar. 25, 1983, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 409 appear at 62 FR 46037, Aug. 29, 1997.

Subpart A—Hospital Insurance Benefits: General Provisions

§ 409.1 Statutory basis.

This part is based on the identified provisions of the following sections of the Social Security Act:

(a) Sections 1812 and 1813 establish the scope of benefits of the hospital insurance program under Medicare Part A and set forth deductible and coinsurance requirements.

(b) Sections 1814 and 1815 establish conditions for, and limitations on, payment for services furnished by providers.

(c) Section 1820 establishes the critical access hospital program.

(d) Section 1861 describes the services covered under Medicare Part A, and benefit periods.

(e) Section 1862(a) specifies exclusions from coverage.

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(f) Section 1881 sets forth the rules for individuals who have end-stage renal disease (ESRD), for organ donors, and for dialysis, transplantation, and other services furnished to ESRD patients.

[60 FR 50441, Sept. 29, 1995, as amended at 65 FR 62646, Oct. 19, 2000]

§ 409.2 Scope.

Subparts A through G of this part describe the benefits available under Medicare Part A and set forth the limitations on those benefits, including certain amounts of payment for which beneficiaries are responsible.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

§ 409.3 Definitions.

As used in this part, unless the context indicates otherwise—

Arrangements means arrangements which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services.

Covered refers to services for which the law and the regulations authorize Medicare payment.

Nominal charge provider means a provider that furnishes services free of charge or at a nominal charge and is either a public provider, or another provider that (1) demonstrates to CMS's satisfaction that a significant portion of its patients are low-income, and (2) requests that payment for its services be determined accordingly.

Participating refers to a hospital or other facility that meets the conditions of participation and has in effect a Medicare provider agreement.

Qualified hospital means a facility that—

(a) Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;

(b) Is not primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care;

(c) Provides 24-hour nursing service in accordance with Sec. 1861(e)(5) of the Act;

(d) If it is a U.S. hospital, is licensed, or approved as meeting the standards for licensing, by the State or local licensing agency; and

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate foreign licensing agency, and for purposes of furnishing nonemergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or by a foreign program under standards that CMS finds to be equivalent to those of JCAHO.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985; 51 FR 41338, Nov. 14, 1986; 71 FR 48135, Aug. 18, 2006]

§ 409.5 General description of benefits.

Hospital insurance (Part A of Medicare) helps pay for inpatient hospital or inpatient CAH services and posthospital SNF care. It also pays for home health services and hospice care. There are limitations on the number of days of care that Medicare can pay for and there are deductible and coinsurance amounts for which the beneficiary is responsible. For each type of service, certain conditions must be met as specified in the pertinent sections of this subpart and in part 418 of this chapter regarding hospice care. Conditions for payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

[71 FR 48135, Aug. 18, 2006]

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

§ 409.10 Included services.

(a) Subject to the conditions, limitations, and exceptions set forth in this subpart, the term “inpatient hospital or inpatient CAH services” means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of