''(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

''(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

''(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

''(4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

''(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

''(b) PILOT PROJECTS TO TEST MODIFIED OR NEW EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

''(1) IN GENERAL.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

''(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

''(A) be voluntary;

''(B) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

''(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

''(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

''(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

''(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

''(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

''(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

''(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the proposed guidelines on—

''(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

''(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

''(5) REPORT ON PILOT PROJECTS.—Not later than 6 months after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1), the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

''(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

''(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

''(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

''(3) increase accuracy by reviewers; and

''(4) educate both physicians and reviewers.

''(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

''(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

''(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

''(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act [this subchapter]; and

''(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

''(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

''(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act [part C of subchapter XI of this chapter].

''(5) REPORT TO CONGRESS.—

''(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

''(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

''(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

''(f) DEFINITIONS.—In this section—

''(1) the term 'rural area' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

''(2) the term 'teaching settings' are those settings described in section 415.150 of title 42, Code of Federal Regulations.''

§ 1395ll. Studies and recommendations

(a) Health care of the aged and disabled

The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged and the disabled, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B of this subchapter; (2) methods for encouraging the further development of efficient and economical forms of health care which are a

constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) Operation and administration of insurance programs

The Secretary shall make a continuing study of the operation and administration of this subchapter (including a validation of the accreditation process of national accreditation bodies under section 1395bb(a) of this title[1] the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972 [42 U.S.C. 1395mm], the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 [42 U.S.C. 1395b–1] and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972 [42 U.S.C. 1395b–1 note]), and shall transmit to the Congress annually a report concerning the operation of such programs.

(Aug. 14, 1935, ch. 531, title XVIII, § 1875, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 332; amended Pub. L. 90–248, title IV, § 402(c), Jan. 2, 1968, 81 Stat. 931; Pub. L. 92–603, title II, §§ 201(c)(7), 222(c), 226(d), 244(d), Oct. 30, 1972, 86 Stat. 1373, 1393, 1404, 1423; Pub. L. 98–369, div. B, title III, § 2354(b)(17), July 18, 1984, 98 Stat. 1101; Pub. L. 99–509, title IX, § 9316(a), Oct. 21, 1986, 100 Stat. 2006; Pub. L. 100–203, title IV, § 4085(i)(20), Dec. 22, 1987, 101 Stat. 1330–133; Pub. L. 100–647, title VIII, § 8413, Nov. 10, 1988, 102 Stat. 3801; Pub. L. 101–234, title III, § 301(b)(5), (d)(2), Dec. 13, 1989, 103 Stat. 1985, 1986; Pub. L. 101–239, title VI, § 6103(b)(3)(A), Dec. 19, 1989, 103 Stat. 2199; Pub. L. 108–173, title I, § 101(e)(7), Dec. 8, 2003, 117 Stat. 2152; Pub. L. 110–275, title I, § 125(b)(4), July 15, 2008, 122 Stat. 2519.)

REFERENCES IN TEXT

Section 226 of the Social Security Amendments of 1972, referred to in subsec. (b), is section 226 of Pub. L. 92–603, which enacted section 1395mm of this title and provisions set out as notes under that section and amended this section and sections 1395f, 1395*l*, and 1396b of this title.

Section 402 of the Social Security Amendments of 1967, referred to in subsec. (b), is section 402 of Pub. L. 90–248, which enacted section 1395b–1 of this title and amended this section.

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b), is section 222(a) of Pub. L. 92–603, which enacted provisions set out as note under section 1395b–1 of this title.

AMENDMENTS

2008—Subsec. (b). Pub. L. 110–275 substituted ''national accreditation bodies under section 1395bb(a) of this title'' for ''the Joint Commission on Accreditation of Hospitals,''.

2003—Subsec. (b). Pub. L. 108–173 substituted ''this subchapter'' for ''the insurance programs under parts A and B of this subchapter''.

1989—Subsec. (c). Pub. L. 101–239 struck out subsec. (c) which related to patient outcome assessment research program.

Subsec. (c)(7). Pub. L. 101–234, § 301(b)(5), (d)(2), amended par. (7) identically, substituting ''date of the enactment of this section'' for ''date of the enactment of this Act''.

1988—Subsec. (c)(3). Pub. L. 100–647 amended par. (3) generally. Prior to amendment, par. (3) read as follows: ''For purposes of carrying out the research program, there are authorized to be appropriated—

''(A) from the Federal Hospital Insurance Trust Fund $4,000,000 for fiscal year 1987 and $5,000,000 for each of fiscal years 1988 and 1989, and

''(B) from the Federal Supplementary Medical Insurance Trust Fund $2,000,000 for fiscal year 1987 and $2,500,000 for each of fiscal years 1988 and 1989.''

1987—Subsec. (c)(3)(B). Pub. L. 100–203 substituted ''fiscal year 1987'' for ''fiscal years 1987''.

1986—Subsec. (c). Pub. L. 99–509 added subsec. (c).

1984—Subsec. (b). Pub. L. 98–369 struck out ''the'' after ''Joint Commission on''.

1972—Subsec. (a). Pub. L. 92–603, § 201(c)(7), inserted ''and the disabled'' after ''aged''.

Subsec. (b). Pub. L. 92–603, §§ 222(c), 226(d)(1), 244(d), substituted ''(including a validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972, the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972)'' for ''(including the experimentation authorized by section 402 of the Social Security Amendments of 1967)''. Pub. L. 92–603, § 226(d)(2), which directed the substitution of ''1972'' for ''1971'', could not be executed because ''1971'' did not appear.

1968—Subsec. (b). Pub. L. 90–248 inserted ''(including the experimentation authorized by section 402 of the Social Security Amendments of 1967'' after ''under parts A and B of this subchapter''.

EFFECTIVE DATE OF 2008 AMENDMENT; TRANSITION RULE

Amendment by Pub. L. 110–275 applicable with respect to accreditations of hospitals granted on or after the date that is 24 months after July 15, 2008, with transition rule, see section 125(d) of Pub. L. 110–275, set out as a note under section 1395bb of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Section 6103(b)(3)(A) of Pub. L. 101–239 provided that the amendment made by that section is effective for fiscal years beginning after fiscal year 1990.

EFFECTIVE DATE OF 1984 AMENDMENT

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

EFFECTIVE DATE OF 1972 AMENDMENT

Amendment by section 226(d) of Pub. L. 92–603 effective with respect to services provided on or after July 1, 1973, see section 226(f) of Pub. L. 92–603, set out as an Effective Date note under section 1395mm of this title.

INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES

Pub. L. 108–173, title II, § 238, Dec. 8, 2003, 117 Stat. 2213, provided that:

''(a) EVALUATION.—

''(1) IN GENERAL.—Not later than the date that is 2 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the 'Institute') shall conduct an evaluation of leading health care performance measures in the public and

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

private sectors and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

''(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

''(A) catalogue, review, and evaluate the validity of leading health care performance measures;

''(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

''(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

''(i) the performance measurement set to be used and how that measurement set will be updated;

''(ii) the payment policy that will reward performance; and

''(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

''(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, other health care providers, health plans, purchasers, and patients.

''(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

''(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act [Dec. 8, 2003], the Institute shall submit to the Secretary and appropriate committees of jurisdiction of the Senate and House of Representatives a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance, including options for updating performance measures, in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act [parts A and B of this subchapter], the Medicare Advantage program under part C of such title [part C of this subchapter], and any other programs under such title XVIII [this subchapter].

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for purposes of conducting the evaluation and preparing the report required by this section.''

GAO STUDY ON ACCESS TO PHYSICIANS' SERVICES

Pub. L. 108–173, title VI, §604, Dec. 8, 2003, 117 Stat. 2301, provided that:

''(a) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

''(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program [part B of this subchapter];

''(2) an examination of changes in the use by beneficiaries of physicians' services over time; and

''(3) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include a determination whether—

''(1) data from claims submitted by physicians under part B of the medicare program [part B of this subchapter] indicate potential access problems for medicare beneficiaries in certain geographic areas; and

''(2) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.''

STUDY ON ENROLLMENT PROCEDURES FOR GROUPS THAT RETAIN INDEPENDENT CONTRACTOR PHYSICIANS

Pub. L. 106–554, §1(a)(6) [title IV, §413], Dec. 21, 2000, 114 Stat. 2763, 2763A–515, provided that:

''(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the current medicare enrollment process for groups that retain independent contractor physicians with particular emphasis on hospital-based physicians, such as emergency department staffing groups. In conducting the evaluation, the Comptroller General shall consult with groups that retain independent contractor physicians and shall—

''(1) review the issuance of individual medicare provider numbers and the possible medicare program integrity vulnerabilities of the current process;

''(2) review direct and indirect costs associated with the current process incurred by the medicare program and groups that retain independent contractor physicians;

''(3) assess the effect on program integrity by the enrollment of groups that retain independent contractor hospital-based physicians; and

''(4) develop suggested procedures for the enrollment of these groups.

''(b) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under subsection (a).''

GAO STUDIES AND REPORTS ON MEDICARE PAYMENTS

Pub. L. 106–554, §1(a)(6) [title IV, §437], Dec. 21, 2000, 114 Stat. 2763, 2763A–527, provided that:

''(a) GAO STUDY ON HCFA POST-PAYMENT AUDIT PROCESS.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study on the post-payment audit process under the medicare program under title XVIII of the Social Security Act [this subchapter] as such process applies to physicians, including the proper level of resources that the Health Care Financing Administration should devote to educating physicians regarding—

''(A) coding and billing;

''(B) documentation requirements; and

''(C) the calculation of overpayments.

''(2) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with specific recommendations for changes or improvements in the post-payment audit process described in such paragraph.

''(b) GAO STUDY ON ADMINISTRATION AND OVERSIGHT.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study on the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the medicare program under title XVIII of the Social Security Act [this subchapter].

''(2) REPORT.—Not later than 18 months after the date of the enactment of this Act [Dec. 21, 2000], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations regarding any area in which—

''(A) a reduction in paperwork, an ease of administration, or an appropriate change in oversight and review may be accomplished; or

''(B) additional payments or education are needed to assist physicians and other health care providers in understanding and complying with any legal or regulatory requirements.''

STUDY AND REPORT REGARDING UTILIZATION OF PHYSICIANS' SERVICES BY MEDICARE BENEFICIARIES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–349, provided that:

''(1) STUDY BY SECRETARY.—The Secretary of Health and Human Services, acting through the Administrator of the Agency for Health Care Policy and Research, shall conduct a study of the issues specified in paragraph (2).

''(2) ISSUES TO BE STUDIED.—The issues specified in this paragraph are the following:

''(A) The various methods for accurately estimating the economic impact on expenditures for physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) [parts A and B of this subchapter] resulting from—

''(i) improvements in medical capabilities;

''(ii) advancements in scientific technology;

''(iii) demographic changes in the types of medicare beneficiaries that receive benefits under such program; and

''(iv) geographic changes in locations where medicare beneficiaries receive benefits under such program.

''(B) The rate of usage of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) among beneficiaries between ages 65 and 74, 75 and 84, 85 and over, and disabled beneficiaries under age 65.

''(C) Other factors that may be reliable predictors of beneficiary utilization of physicians' services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

''(3) REPORT TO CONGRESS.—Not later than 3 years after the date of the enactment of this Act [Nov. 29, 1999], the Secretary of Health and Human Services shall submit a report to Congress setting forth the results of the study conducted pursuant to paragraph (1), together with any recommendations the Secretary determines are appropriate.

''(4) MEDPAC REPORT TO CONGRESS.—Not later than 180 days after the date of submission of the report under paragraph (3), the Medicare Payment Advisory Commission shall submit a report to Congress that includes—

''(A) an analysis and evaluation of the report submitted under paragraph (3); and

''(B) such recommendations as it determines are appropriate.''

STUDY OF ADULT DAY CARE SERVICES

Pub. L. 100–360, title II, §208, July 1, 1988, 102 Stat. 732, as amended by Pub. L. 100–485, title VI, §608(d)(8), Oct. 13, 1988, 102 Stat. 2415, directed Secretary of Health and Human Services to conduct a survey of adult day care services in United States and to report to Congress, by not later than 1 year after July 1, 1988, on the information collected in the survey, prior to repeal by Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981.

STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE

Section 9313(d) of Pub. L. 99–509, as amended by Pub. L. 100–203, title IV, §4085(i)(21)(A), Dec. 22, 1987, 101 Stat. 1330–133, directed Secretary of Health and Human Services to arrange, with the National Academy of Sciences or other appropriate nonprofit private entity, for a study to design a strategy for reviewing and assuring the quality of care for which payment may be made under this subchapter, specified items to be included in the study, and directed Secretary to submit to Congress, not later than Jan. 1, 1990, a report on the study with recommendations with respect to strengthening quality assurances and review activities for services furnished under the medicare program.

SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER

For treatment of hospitals in States which have had a waiver approved under this section, upon termination of waiver, see section 9202(j) of Pub. L. 99–272, as amended, set out as a note under section 1395ww of this title.

DRUG DETOXIFICATION MEDICARE COVERAGE AND FACILITY INCENTIVES

Pub. L. 96–499, title IX, §931(f), Dec. 5, 1980, 94 Stat. 2634, which related to a study of medicare coverage of certain additional detoxification-related services, was repealed by Pub. L. 97–35, title XXI, §2121(h), Aug. 13, 1981, 95 Stat. 796.

LEGISLATIVE RECOMMENDATIONS REGARDING REIMBURSEMENT FOR OPTOMETRISTS' SERVICES

Pub. L. 96–499, title IX, §937(b), Dec. 5, 1980, 94 Stat. 2640, provided that the Secretary of Health and Human Services submit to the Congress by Jan. 1, 1982, legislative recommendations with respect to reimbursement under title XVIII of the Social Security Act [this subchapter] for services furnished by optometrists in connection with cataracts and such other services which they are legally authorized to perform.

DEMONSTRATION PROJECTS, STUDIES, AND REPORTS: NUTRITIONAL THERAPY, SECOND OPINION COST-SHARING, SERVICES OF REGISTERED DIETITIANS, SERVICES OF CLINICAL SOCIAL WORKERS, ORTHOPEDIC SHOES, RESPIRATORY THERAPY SERVICES, AND FOOT CONDITIONS; GRANTS, PAYMENTS, AND EXPENDITURES

Pub. L. 96–499, title IX, §958, Dec. 5, 1980, 94 Stat. 2648, directed Secretary of Health and Human Services to carry out certain demonstration projects and conduct certain studies as follows: (a) a demonstration project to determine extent to which nutritional therapy in early renal failure could retard the disease with resultant substantive deferment of dialysis, and aspects of making such therapy available under this subchapter, report to Congress to be submitted within twenty-four months of Dec. 5, 1980; (b) demonstration projects with respect to waiving the applicable cost sharing amounts which beneficiaries under this subchapter had to pay for obtaining a second opinion on having surgery, report to be submitted within one year after Dec. 5, 1980; (c) a study of conditions under which services of registered dietitians could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (d) demonstration projects to determine aspects of making services of clinical social workers more generally available under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; (e) a study of methods for providing coverage under part B of this subchapter for orthopedic shoes for individuals with disabling or deforming conditions requiring special fitting considerations, or requiring special shoes in conjunction with the use of an orthosis or foot support, report to be submitted no later than July 1, 1981; (f) a study of conditions under which services with respect to respiratory therapy could be covered as a home health benefit under this subchapter, report to be submitted within twenty-four months of Dec. 5, 1980; and (g) a study analyzing cost effects of alternative approaches to improving coverage under this subchapter for treatment of various types of foot conditions, report to be submitted within twenty-four months of Dec. 5, 1980. Payments and expenditures for such studies and projects were to be made in appropriate part from the Federal Hospital Insurance Trust Fund established by section 1395i of this title, and the Federal Supplementary Medical Insurance Trust Fund established by section 1395t of this title.

DEMONSTRATION PROJECT RELATING TO THE TERMINALLY ILL

Pub. L. 96–265, title V, §506, June 9, 1980, 94 Stat. 475, authorized Secretary of Health and Human Services to

provide for participation, by Social Security Administration, in a demonstration project relating to the terminally ill then being conducted within the Department of Health and Human Services, the purpose of such participation to be to study impact on terminally ill of provisions of disability programs administered by Social Security Administration and to determine how best to provide services needed by persons who were terminally ill through programs over which the Social Security Administration had administrative responsibility, and authorized to be appropriated necessary sums not in excess of $2,000,000 for any fiscal year.

REPORT TO CONGRESS WITH RESPECT TO URBAN OR RURAL COMPREHENSIVE MENTAL HEALTH CENTERS AND CENTERS FOR TREATMENT OF ALCOHOLISM AND DRUG ABUSE; SUBMISSION NO LATER THAN JUNE 13, 1978

Pub. L. 95–210, §4, Dec. 13, 1977, 91 Stat. 1490, directed Secretary of Health, Education, and Welfare to submit to Congress, no later than six months after Dec. 13, 1977, a report on the advantages and disadvantages of extending coverage under this subchapter to urban or rural comprehensive mental health centers and to centers for treatment of alcoholism and drug abuse.

STUDY AND REVIEW BY COMPTROLLER GENERAL OF ADMINISTRATIVE STRUCTURE FOR PROCESSING MEDICARE CLAIMS; REPORT TO CONGRESS

Pub. L. 95–142, §12, Oct. 25, 1977, 91 Stat. 1197, directed Comptroller General to conduct a comprehensive study and review of administrative structure established for processing of claims under this subchapter for purpose of determining whether and to what extent more efficient claims administration under this subchapter could be achieved and directed Comptroller General to submit to Congress no later than July 1, 1979, a complete report with respect to such study and review.

REPORT BY SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON DELIVERY OF HOME HEALTH AND OTHER IN-HOME SERVICES; CONTENTS; CONSULTATION REQUIREMENTS; SUBMISSION TO CONGRESS

Pub. L. 95–142, §18, Oct. 25, 1977, 91 Stat. 1202, directed Secretary of Health, Education, and Welfare, not later than one year after Oct. 25, 1977, to submit to appropriate committees of Congress a report analyzing, evaluating, and making recommendations with respect to all aspects of delivery of home health and other in-home services authorized to be provided under subchapters XVIII, XIX, and XX of this chapter.

§ 1395mm. Payments to health maintenance organizations and competitive medical plans

(a) Rates and adjustments

(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B of this subchapter only.

For purposes of this section, the term ''risk-sharing contract'' means a contract entered into under subsection (g) of this section and the term ''reasonable cost reimbursement contract'' means a contract entered into under subsection (h) of this section.

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The annual per capita rate of payment for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)) for that class.

(D) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (C) and except as provided in subsection (g)(2) of this section, to the organization for each individual enrolled with the organization under this section.

(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) of this section at the time the individual enrolled with the organization.

(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(ii) In each announcement made under subparagraph (A) for a year (beginning with the announcement for 1991), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each county (or equivalent area) which is in whole or in part within the service area of such an organization.