Payment Advisory Commission, in its study conducted pursuant to subsection (a) of section 411 of BBRA [Pub. L. 106–113, §1000(a)(6) [title IV, §411], set out as a note below] (113 Stat. 1501A–377), shall include—

''(1) in such study an analysis of the impact of volume on the per unit cost of rural hospitals with psychiatric units; and

''(2) in its report under subsection (b) of such section a recommendation on whether special treatment for such hospitals may be warranted.''

MEDPAC STUDY ON COMPLEXITY OF MEDICARE PROGRAM AND LEVELS OF BURDENS PLACED ON PROVIDERS THROUGH FEDERAL REGULATIONS

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §229(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–357, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall undertake a comprehensive study to review the regulatory burdens placed on all classes of health care providers under parts A and B of the medicare program under title XVIII of the Social Security Act [this subchapter] and to determine the costs these burdens impose on the nation's health care system. The study shall also examine the complexity of the current regulatory system and its impact on providers.

''(2) REPORT.—Not later than December 31, 2001, the Commission shall submit to Congress one or more reports on the study conducted under paragraph (1). The report shall include recommendations regarding—

''(A) how the Health Care Financing Administration can reduce the regulatory burdens placed on patients and providers; and

''(B) legislation that may be appropriate to reduce the complexity of the medicare program, including improvement of the rules regarding billing, compliance, and fraud and abuse.''

MEDPAC REPORT

Pub. L. 106–113, div. B, §1000(a)(6) [title III, §312(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–365, provided that: ''The Medicare Payment Advisory Commission shall include in its report submitted to Congress in March of 2001 recommendations regarding the appropriateness of the initial residency period used under section 1886(h)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)) for other residency training programs in a specialty that require preliminary years of study in another specialty.''

MEDPAC STUDY OF RURAL PROVIDERS

Pub. L. 106–113, div. B, §1000(a)(6) [title IV, §411], Nov. 29, 1999, 113 Stat. 1536, 1501A–377, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of rural providers furnishing items and services for which payment is made under title XVIII of the Social Security Act [this subchapter]. Such study shall examine and evaluate the adequacy and appropriateness of the categories of special payments (and payment methodologies) established for rural hospitals under the medicare program, and the impact of such categories on beneficiary access and quality of health care services.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this Act [Nov. 29, 1999], the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subsection (a).''

QUALITY IMPROVEMENT STANDARDS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §520(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–386, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriate quality improvement standards that should apply to—

''(A) each type of Medicare+Choice plan described in section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)), including each type of Medicare+Choice plan that is a coordinated care plan (as described in subparagraph (A) of such section); and

''(B) the original medicare fee-for-service program under parts A and B [sic] title XVIII of such Act (42 U.S.C. 1395 et seq.) [parts A and B of this subchapter].

''(2) CONSIDERATIONS.—Such study shall specifically examine the effects, costs, and feasibility of requiring entities, physicians, and other health care providers that provide items and services under the original medicare fee-for-service program to comply with quality standards and related reporting requirements that are comparable to the quality standards and related reporting requirements that are applicable to Medicare+Choice organizations.

''(3) REPORT.—Not later than 2 years after the date of the enactment of this Act [Nov. 29, 1999], such Commission shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that it determines to be appropriate as a result of such study.''

INITIAL TERMS OF ADDITIONAL MEMBERS

Pub. L. 105–277, div. J, title V, §5202(b), Oct. 21, 1998, 112 Stat. 2681–917, provided that:

''(1) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission (under section 1805(c)(3) of such Act (42 U.S.C. 1395b–6(c)(3))[)], the initial terms of the two additional members of the Commission provided for by the amendment under subsection (a) [amending this section] are as follows:

''(A) One member shall be appointed for one year.

''(B) One member shall be appointed for two years.

''(2) COMMENCEMENT OF TERMS.—Such terms shall begin on May 1, 1999.''

INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS

Pub. L. 105–33, title IV, §4804(c), Aug. 5, 1997, 111 Stat. 552, provided that: ''The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act [subsec. (b)(1)(B) of this section] recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act [sections 1395eee(d) and 1396u–4(d) of this title] and on the treatment of private, for-profit entities as PACE providers.''

§ 1395b–7. Explanation of medicare benefits

(a) In general

The Secretary shall furnish to each individual for whom payment has been made under this subchapter (or would be made without regard to any deductible) a statement which—

(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; and

(2) includes a notice of the individual's right to request an itemized statement (as provided in subsection (b) of this section).

(b) Request for itemized statement for medicare items and services

(1) In general

An individual may submit a written request to any physician, provider, supplier, or any other person (including an organization, agency, or other entity) for an itemized statement for any item or service provided to such individual by such person with respect to which payment has been made under this subchapter.

(2) 30-day period to furnish statement

(A) In general

Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describ-

ing each item or service provided to the individual requesting the itemized statement.

(B) Penalty

Whoever knowingly fails to furnish an itemized statement in accordance with subparagraph (A) shall be subject to a civil money penalty of not more than $100 for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a–7a of this title are imposed and collected under that section.

(3) Review of itemized statement

(A) In general

Not later than 90 days after the receipt of an itemized statement furnished under paragraph (1), an individual may submit a written request for a review of the itemized statement to the Secretary.

(B) Specific allegations

A request for a review of the itemized statement shall identify—

(i) specific items or services that the individual believes were not provided as claimed, or

(ii) any other billing irregularity (including duplicate billing).

(4) Findings of Secretary

The Secretary shall, with respect to each written request submitted under paragraph (3), determine whether the itemized statement identifies specific items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under this subchapter.

(5) Recovery of amounts

The Secretary shall take all appropriate measures to recover amounts unnecessarily paid under this subchapter with respect to a statement described in paragraph (4).

(Aug. 14, 1935, ch. 531, title XVIII, § 1806, as added Pub. L. 105–33, title IV, § 4311(b)(1), Aug. 5, 1997, 111 Stat. 385.)

EFFECTIVE DATE

Pub. L. 105–33, title IV, § 4311(b)(3), Aug. 5, 1997, 111 Stat. 386, provided that:

''(A) STATEMENT BY SECRETARY.—Paragraph (1) of section 1806(a) of the Social Security Act [subsec. (a)(1) of this section], as added by paragraph (1), and the repeal made by paragraph (2) [amending section 1395b–5 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

''(B) ITEMIZED STATEMENT.—Paragraph (2) of section 1806(a) and section 1806(b) of the Social Security Act [subsecs. (a)(2) and (b) of this section], as so added, shall take effect not later than January 1, 1999.''

INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS

Pub. L. 108–173, title IX, § 925, Dec. 8, 2003, 117 Stat. 2396, provided that:

''(a) IN GENERAL.—The Secretary [of Health and Human Services] shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act [part A of this subchapter], there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

''(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act [Dec. 8, 2003].''

§ 1395b–8. Chronic care improvement

(a) Implementation of chronic care improvement programs

(1) In general

The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this subchapter for targeted beneficiaries with one or more threshold conditions.

(2) Definitions

For purposes of this section:

(A) Chronic care improvement program

The term ''chronic care improvement program'' means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c) of this section.

(B) Chronic care improvement organization

The term ''chronic care improvement organization'' means an entity that has entered into an agreement under subsection (b) or (c) of this section to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

(C) Care management plan

The term ''care management plan'' means a plan established under subsection (d) of this section for a participant in a chronic care improvement program.

(D) Threshold condition

The term ''threshold condition'' means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

(E) Targeted beneficiary

The term ''targeted beneficiary'' means, with respect to a chronic care improvement program, an individual who—

(i) is entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, but not enrolled in a plan under part C of this subchapter;