''(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

''(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

''(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

''(2) identify any new data needs and a methodology to address new data needs;

''(3) plan for the collection of such data in a data warehouse; and

''(4) develop a research agenda using such data.

''(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

''(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act [Dec. 8, 2003], the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.''

§ 1395b–9. Provisions relating to administration

(a) Coordinated administration of medicare prescription drug and Medicare Advantage programs

(1) In general

There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).

(2) Director

Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

(3) Duties

The duties described in this paragraph are the following:

(A) The administration of parts C and D.

(B) The provision of notice and information under section 1395b–2 of this title.

(C) Such other duties as the Secretary may specify.

(4) Deadline

The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.

(b) Employment of management staff

(1) In general

The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

(2) Eligibility

To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

(A) The review, negotiation, and administration of health care contracts.

(B) The design of health care benefit plans.

(C) Actuarial sciences.

(D) Compliance with health plan contracts.

(E) Consumer education and decision making.

(F) Any other area specified by the Secretary that requires specialized management or other expertise.

(3) Rates of payment

(A) Performance-related pay

Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

(B) Limitation

In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5.

(c) Medicare Beneficiary Ombudsman

(1) In general

The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this subchapter.

(2) Duties

The Medicare Beneficiary Ombudsman shall—

(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary;

(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

(iii) assistance to such individuals in presenting information under section 1395r(i)(4)(C) of this title (relating to income-related premium adjustment;[1] and

(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the adminis-

[1] So in original. A closing parenthesis probably should precede the semicolon.

tration of this subchapter as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(3) Working with health insurance counseling programs

To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 1395b–4 of this title) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.

(d) Pharmaceutical and technology ombudsman

(1) In general

Not later than 12 months after December 13, 2016, the Secretary shall provide for a pharmaceutical and technology ombudsman within the Centers for Medicare & Medicaid Services who shall receive and respond to complaints, grievances, and requests that—

(A) are from entities that manufacture pharmaceutical, biotechnology, medical device, or diagnostic products that are covered or for which coverage is being sought under this subchapter; and

(B) are with respect to coverage, coding, or payment under this subchapter for such products.

(2) Application

The second sentence of subsection (c)(2) shall apply to the ombudsman under subparagraph (A) in the same manner as such sentence applies to the Medicare Beneficiary Ombudsman under subsection (c).

(Aug. 14, 1935, ch. 531, title XVIII, § 1808, as added and amended Pub. L. 108–173, title IX, §§ 900(a), (b), 923(a), Dec. 8, 2003, 117 Stat. 2369, 2393; Pub. L. 114–255, div. A, title IV, § 4010, Dec. 13, 2016, 130 Stat. 1185.)

AMENDMENTS

2016—Subsec. (d). Pub. L. 114–255 added subsec. (d).

2003—Subsec. (b). Pub. L. 108–173, § 900(b), added subsec. (b).

Subsec. (c). Pub. L. 108–173, § 923(a), added subsec. (c).

DEADLINE FOR APPOINTMENT

Pub. L. 108–173, title IX, § 923(b), Dec. 8, 2003, 117 Stat. 2394, provided that: ''By not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall appoint the Medicare Beneficiary Ombudsman under section 1808(c) of the Social Security Act [42 U.S.C. 1395b–9(c)], as added by subsection (a).''

§ 1395b–10. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, and gender. In conducting such evaluation, the Secretary shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers and health plans participating under this subchapter.

(3) Improving Medicare program data on race, ethnicity, and gender.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after July 15, 2008, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, and gender for the original Medicare fee-for-service program under parts A and B, the Medicare Advantage program under part C, and the Medicare prescription drug program under part D; and

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w–22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on the basis of race, ethnicity, and gender.

(2) Reports on data analyses

Not later than 4 years after July 15, 2008, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for Medicare beneficiaries based on analyses of the data collected under subsection (c).

(c) Implementing effective approaches

Not later than 24 months after July 15, 2008, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, and gender.

(Aug. 14, 1935, ch. 531, title XVIII, § 1809, as added Pub. L. 110–275, title I, § 185, July 15, 2008, 122 Stat. 2587.)

PART A—HOSPITAL INSURANCE BENEFITS FOR AGED AND DISABLED

§ 1395c. Description of program

The insurance program for which entitlement is established by sections 426 and 426–1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain government