

made to make MSA plans a viable option under the Medicare+Choice program.

GAO AUDIT AND REPORTS ON PROVISION OF
MEDICARE+CHOICE HEALTH INFORMATION TO BENE-
FIICIARIES

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §553(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-393, provided that:

“(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) to eligible medicare beneficiaries.

“(3) [(2)] REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a) [enacting provisions set out as a note under section 1395ss of this title], together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) to eligible medicare beneficiaries.”

ENROLLMENT TRANSITION RULE

Pub. L. 105-33, title IV, §4002(c), Aug. 5, 1997, 111 Stat. 329, provided that: “An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act [42 U.S.C. 1395w-21 et seq.] if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).”

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL

Pub. L. 105-33, title IV, §4002(f)(2), Aug. 5, 1997, 111 Stat. 330, directed the Secretary of Health and Human Services to submit to Congress, no later than 6 months after Aug. 5, 1997, proposed technical and conforming amendments in the law as required by the provisions of chapter 1 (§§4001-4006) of subtitle A of title IV of Pub. L. 105-33.

REPORT ON INTEGRATION AND TRANSITION

Pub. L. 105-33, title IV, §4014(c), Aug. 5, 1997, 111 Stat. 337, directed the Secretary of Health and Human Services to submit to Congress, no later than Jan. 1, 1999, a plan which provided for the integration of health plans offered by social health maintenance organizations and similar plans as an option under the Medicare+Choice program under this part, for a transition for such organizations operating under demonstration project authority, and for appropriate payment levels for plans offered by such organizations.

MEDICARE ENROLLMENT DEMONSTRATION PROJECT

Pub. L. 105-33, title IV, §4018, Aug. 5, 1997, 111 Stat. 346, provided that:

“(a) DEMONSTRATION PROJECT.—

“(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the ‘project’) for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.] (as added by section 4001 of this Act), in an area.

“(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

“(A) the design of the project;

“(B) the selection criteria for the third-party contractor; and

“(C) the establishment of performance standards, as described in paragraph (3).

“(3) PERFORMANCE STANDARDS.—

“(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

“(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

“(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

“(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.] (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

“(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

“(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.”

§ 1395w-22. Benefits and beneficiary protections

(a) Basic benefits

(1) Requirement

(A) In general

Except as provided in section 1395w-28(b)(3) of this title for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this subchapter and part A of subchapter XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w-24(f)(1)(A) of this title).

(B) Benefits under the original medicare fee-for-service program option defined

(i) In general

For purposes of this part, the term “benefits under the original medicare fee-for-service program option” means, subject to subsection (m), those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) Special rule for regional plans

In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken

into account, with respect to the application of section 1395w-27a(b)(2) of this title, such expenses only with respect to subparagraph (A) of such section.

(iii) Limitation on variation of cost sharing for certain benefits

Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) Services described

The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1395rr(b)(14)(B) of this title).

(III) Skilled nursing care.

(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) Exception

In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(2) Satisfaction of requirement

(A) In general

A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) Reference to related provisions

For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see subsection (k) and section 1395cc(a)(1)(O) of this title, and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1395w-24(e) of this title.

(C) Election of uniform coverage determination

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply

with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) Supplemental benefits

(A) Benefits included subject to Secretary's approval

Subject to subparagraph (D), each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment with Medicare+Choice eligible individuals with the organization.

(B) At enrollees' option

(i) In general

Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) Special rule for MSA plans

A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1395w-28(b)(2)(B) of this title. In applying the previous sentence, health benefits described in section 1395ss(u)(2)(B) of this title shall not be treated as covering such deductible.

(C) Application to Medicare+Choice private fee-for-service plans

Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with subsection (k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w-24(e)(4)(B) of this title.

(D) Expanding supplemental benefits to meet the needs of chronically ill enrollees

(i) In general

For plan year 2020 and subsequent plan years, in addition to any supplemental health care benefits otherwise provided under this paragraph, an MA plan, including a specialized MA plan for special needs individuals (as defined in section 1395w-28(b)(6) of this title), may provide supplemental benefits described in clause (ii) to a chronically ill enrollee (as defined in clause (iii)).

(ii) Supplemental benefits described

(I) In general

Supplemental benefits described in this clause are supplemental benefits

that, with respect to a chronically ill enrollee, have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee and may not be limited to being primarily health related benefits.

(II) Authority to waive uniformity requirements

The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this subparagraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

(iii) Chronically ill enrollee defined

In this subparagraph, the term “chronically ill enrollee” means an enrollee in an MA plan that the Secretary determines—

(I) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;

(II) has a high risk of hospitalization or other adverse health outcomes; and

(III) requires intensive care coordination.

(4) Organization as secondary payer

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) National coverage determinations and legislative changes in benefits

If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1395w-23(b) of this title and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1395w-23 of this title included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to con-

tracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1395w-21(i)(1) of this title shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) Special benefit rules for regional plans

In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1395w-27a(b) of this title.

(7) Limitation on cost-sharing for dual eligibles and qualified medicare beneficiaries

In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1396u-5(c)(6) of this title) or a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1395w-28(b)(6)(B)(ii) of this title, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under subchapter XIX if the individual were not enrolled in such plan.

(b) Antidiscrimination

(1) Beneficiaries

A Medicare Advantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.¹ The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.

(2) Providers

A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan’s enrollees or from establishing any measure designed to

¹ See References in Text note below.

maintain quality and control costs consistent with the responsibilities of the plan.

(c) Disclosure requirements

(1) Detailed description of plan provisions

A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) Service area

The plan's service area.

(B) Benefits

Benefits offered under the plan, including information described in section 1395w-21(d)(3)(A) of this title and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) Access

The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option).

(D) Out-of-area coverage

Out-of-area coverage provided by the plan.

(E) Emergency coverage

Coverage of emergency services, including—

- (i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;
- (ii) the process and procedures of the plan for obtaining emergency services; and
- (iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(F) Supplemental benefits

Supplemental benefits available from the organization offering the plan, including—

- (i) whether the supplemental benefits are optional,
- (ii) the supplemental benefits covered, and
- (iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) Prior authorization rules

Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) Plan grievance and appeals procedures

All plan appeal or grievance rights and procedures.

(I) Quality improvement program

A description of the organization's quality improvement program under subsection (e).

(2) Disclosure upon request

Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1395w-21(d)(2)(A) of this title.

(B) Information on procedures used by the organization to control utilization of services and expenditures.

(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

(D) An overall summary description as to the method of compensation of participating physicians.

(d) Access to services

(1) In general

A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) Guidelines respecting coordination of post-stabilization care

A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and

timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1395dd of this title.

(3) “Emergency services” defined

In this subsection—

(A) In general

The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) Emergency medical condition based on prudent layperson

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(4) Assuring access to services in Medicare+Choice private fee-for-service plans

In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Subject to paragraphs (5) and (6), the Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) with a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1),

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with

respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.

(5) Requirement of certain nonemployer Medicare Advantage private fee-for-service plans to use contracts with providers

(A) In general

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1395w-27(i) of this title operating in a network area (as defined in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(B) Network area defined

For purposes of subparagraph (A), the term “network area” means, for a plan year, an area which the Secretary identifies (in the Secretary’s announcement of the proposed payment rates for the previous plan year under section 1395w-23(b)(1)(B) of this title) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

(C) Network-based plan defined

(i) In general

For purposes of subparagraph (B), the term “network-based plan” means—

(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1395w-21(a)(2)(A)(i) of this title;

(II) a network-based MSA plan; and

(III) a reasonable cost reimbursement plan under section 1395mm of this title.

(ii) Exclusion of non-network regional PPOS

The term “network-based plan” shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.

(6) Requirement of all employer Medicare Advantage private fee-for-service plans to use contracts with providers

For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1395w-27(i) of this title, the plan shall meet the access standards under paragraph (4) only through

entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(e) Quality improvement program

(1) In general

Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization.

(2) Chronic care improvement programs

As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) Data

(A) Collection, analysis, and reporting

(i) In general

Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

(ii) Special requirements for specialized MA plans for special needs individuals

In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such data may be based on claims data and shall be at the plan level.

(iii) Application to local preferred provider organizations and MA regional plans

Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans

and to MA regional plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) Definition of preferred provider organization plan

In this subparagraph, the term “preferred provider organization plan” means an MA plan that—

(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) Limitations

(i) Types of data

The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) Changes in types of data

Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) Construction

Nothing in the² subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1395w-21(d)(4)(D) of this title.

(4) Treatment of accreditation

(A) In general

The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically re-accredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1395w-26 of this title to carry out the requirements in such clause.

(B) Requirements described

The provisions described in this subparagraph are the following:

(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).

² So in original. Probably should be “this”.

(ii) Subsection (b) (relating to anti-discrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(vii) The requirements described in section 1395w-104(j) of this title, to the extent such requirements apply under section 1395w-131(c) of this title.

(C) Timely action on applications

The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1395bb(a)(2) of this title, whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) Construction

Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1395w-27 of this title, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(f) Grievance mechanism

Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) Coverage determinations, reconsiderations, and appeals

(1) Determinations by organization

(A) In general

A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) Explanation of determination

Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) Reconsiderations

(A) In general

The organization shall provide for reconsideration of a determination described in

paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) Physician decision on certain reconsiderations

A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) Expedited determinations and reconsiderations

(A) Receipt of requests

(i) Enrollee requests

An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) Physician requests

A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) Organization procedures

(i) In general

The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) Expedition required for physician requests

In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) Timely response

In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request

for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) Independent review of certain coverage denials

The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) Appeals

An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 405 of this title as provided in this paragraph, and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.

(h) Confidentiality and accuracy of enrollee records

Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

- (1) to safeguard the privacy of any individually identifiable enrollee information;
- (2) to maintain such records and information in a manner that is accurate and timely; and
- (3) to assure timely access of enrollees to such records and information.

(i) Information on advance directives

Each Medicare+Choice organization shall meet the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).

(j) Rules regarding provider participation

(1) Procedures

Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

- (A) providing notice of the rules regarding participation,
- (B) providing written notice of participation decisions that are adverse to physicians, and
- (C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) Consultation in medical policies

A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) Prohibiting interference with provider advice to enrollees

(A) In general

Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Conscience protection

Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

- (i) objects to the provision of such service on moral or religious grounds; and
- (ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) Construction

Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Re-

tirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(D) “Health care professional” defined

For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional’s services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Limitations on physician incentive plans

(A) In general

No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group.

(B) “Physician incentive plan” defined

In this paragraph, the term “physician incentive plan” means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) Limitation on provider indemnification

A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization

under this part by the organization’s denial of medically necessary care.

(6) Special rules for Medicare+Choice private fee-for-service plans

For purposes of applying this part (including subsection (k)(1)) and section 1395cc(a)(1)(O) of this title, a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity—

(i) has been informed of the individual’s enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7) Promotion of e-prescribing by MA plans

(A) In general

An MA–PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1395w-104(e) of this title.

(B) Considerations

Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

(iii) reductions in adverse drug interactions; and

(iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) Structure

Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1395w-104(c)(2)(E)¹ of this title.

(k) Treatment of services furnished by certain providers

(1) In general

Except as provided in paragraph (2), a physician or other entity (other than a provider of

services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1395w-21(a)(2)(A) of this title or with an organization offering an MSA plan shall accept as payment in full for covered services under this subchapter that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this subchapter (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) Application to Medicare+Choice private fee-for-service plans

(A) Balance billing limits under Medicare+Choice private fee-for-service plans in case of contract providers

(i) In general

In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this subchapter that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) Procedures to enforce limits

The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1395w-4(g)(1)(A) of this title, in order to carry out the previous sentence.

(iii) Assuring enforcement

If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1395w-27(g) of this title.

(B) Enrollee liability for noncontract providers

For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see subsection (a)(2); or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1395cc(a)(1)(O) of this title.

(C) Information on beneficiary liability

(i) In general

Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services

for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) Advance notice before receipt of inpatient hospital services and certain other services

In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(I) Return to home skilled nursing facilities for covered post-hospital extended care services

(1) Ensuring return to home SNF

(A) In general

In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) Enrollee election

The enrollee elects to receive such coverage through such facility.

(ii) SNF agreement

The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) Manner of payment to home SNF

The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) No less favorable coverage

The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect

to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) Rule of construction

Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for Medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) Definitions

In this subsection:

(A) Home skilled nursing facility

The term “home skilled nursing facility” means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF residence at time of admission

The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF in continuing care retirement community

A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF residence of spouse at time of discharge

The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) Continuing care retirement community

The term “continuing care retirement community” means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

(m) Provision of additional telehealth benefits

(1) MA plan option

For plan year 2020 and subsequent plan years, subject to the requirements of paragraph (3), an MA plan may provide additional telehealth benefits (as defined in paragraph (2)) to individuals enrolled under this part.

(2) Additional telehealth benefits defined

(A) In general

For purposes of this subsection and section 1395w-24 of this title:

(i) Definition

The term “additional telehealth benefits” means services—

(I) for which benefits are available under part B, including services for which payment is not made under section 1395m(m) of this title due to the conditions for payment under such section; and

(II) that are identified for such year as clinically appropriate to furnish using electronic information and telecommunications technology when a physician (as defined in section 1395x(r) of this title) or practitioner (described in section 1395u(b)(18)(C) of this title) providing the service is not at the same location as the plan enrollee.

(ii) Exclusion of capital and infrastructure costs and investments

The term “additional telehealth benefits” does not include capital and infrastructure costs and investments relating to such benefits.

(B) Public comment

Not later than November 30, 2018, the Secretary shall solicit comments on—

(i) what types of items and services (including those provided through supplemental health care benefits, such as remote patient monitoring, secure messaging, store and forward technologies, and other non-face-to-face communication) should be considered to be additional telehealth benefits; and

(ii) the requirements for the provision or furnishing of such benefits (such as training and coordination requirements).

(3) Requirements for additional telehealth benefits

The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:

(A) Physician or practitioner qualifications (other than licensure) and other requirements such as specific training.

(B) Factors necessary for the coordination of such benefits with other items and services including those furnished in-person.

(C) Such other areas as determined by the Secretary.

(4) Enrollee choice

If an MA plan provides a service as an additional telehealth benefit (as defined in paragraph (2))—

(A) the MA plan shall also provide access to such benefit through an in-person visit (and not only as an additional telehealth benefit); and

(B) an individual enrollee shall have discretion as to whether to receive such service through the in-person visit or as an additional telehealth benefit.

(5) Treatment under MA

For purposes of this subsection and section 1395w-24 of this title, if a plan provides additional telehealth benefits, such additional telehealth benefits shall be treated as if they were benefits under the original Medicare fee-for-service program option.

(6) Construction

Nothing in this subsection shall be construed as affecting the requirement under subsection (a)(1) that MA plans provide enrollees with items and services (other than hospice care) for which benefits are available under parts A and B, including benefits available under section 1395m(m) of this title.

(n) Provision of information relating to the safe disposal of certain prescription drugs**(1) In general**

In the case of an individual enrolled under an MA or MA-PD plan who is furnished an in-home health risk assessment on or after January 1, 2021, such plan shall ensure that such assessment includes information on the safe disposal of prescription drugs that are controlled substances that meets the criteria established under paragraph (2). Such information shall include information on drug takeback programs that meet such requirements determined appropriate by the Secretary and information on in-home disposal.

(2) Criteria

The Secretary shall, through rulemaking, establish criteria the Secretary determines appropriate with respect to information provided to an individual to ensure that such information sufficiently educates such individual on the safe disposal of prescription drugs that are controlled substances.

(Aug. 14, 1935, ch. 531, title XVIII, § 1852, as added Pub. L. 105-33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 286; amended Pub. L. 106-113, div. B, § 1000(a)(6) [title III, § 321(k)(6)(B), title V, §§ 518, 520(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A-367, 1501A-384, 1501A-385; Pub. L. 106-554, § 1(a)(6) [title V, § 521(b), title VI, §§ 611(b), 615, 616, 621(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-543, 2763A-560, 2763A-561, 2763A-564; Pub. L. 108-173, title I, § 102(b), title II, §§ 211(j), 221(d)(3), 222(a)(2), (3), (h), (l)(1), 233(a)(1), (2), (c), title VII, § 722(a), (b), title IX, §§ 900(e)(1)(F), 940(b)(2)(A), 948(b)(2), Dec. 8, 2003, 117 Stat. 2153, 2180, 2193, 2195, 2196, 2204, 2206, 2209, 2347, 2348, 2371, 2417, 2426; Pub. L. 110-275, title I, §§ 125(b)(6), 162(a)(1)-(3)(A), 163(a), (b), 164(f)(1), 165(a), July 15, 2008, 122 Stat. 2519, 2569-2571, 2574, 2575; Pub. L. 111-148, title III, § 3202(a)(1), Mar. 23, 2010, 124 Stat. 454; Pub. L. 114-255, div. C, title XVII, § 17006(a)(2)(A), (c)(1), Dec. 13, 2016, 130 Stat. 1334, 1335; Pub. L. 115-123, div. E, title III, §§ 50322(a), 50323(a), Feb. 9, 2018, 132 Stat. 201, 202; Pub. L. 115-271, title VI, § 6103(a), Oct. 24, 2018, 132 Stat. 4005.)

APPLICABILITY OF AMENDMENT

Amendment of section by section 17006(a)(2)(A), (c)(1) of Pub. L. 114-255 applicable with respect to plan years beginning on or after Jan. 1, 2021. See 2016 Amendment notes below.

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (b)(1), is section 2702 of act July 1, 1944, which was classified to section 300gg-1 of this title, was amended by Pub. L. 111-148, title I, § 1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to sub-

secs. (b) to (f) of section 300gg-4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111-148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg-1 of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (j)(3)(C), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 832, as amended, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 1395w-104(c)(2)(E) of this title, referred to in subsec. (j)(7)(C), was redesignated section 1395w-104(c)(2)(G) of this title by Pub. L. 111-148, title X, § 10328(a)(1), Mar. 23, 2010, 124 Stat. 964.

AMENDMENTS

2018—Subsec. (a)(1)(B)(i). Pub. L. 115-123, § 50323(a)(1), inserted “, subject to subsection (m),” after “means”.

Subsec. (a)(3)(A). Pub. L. 115-123, § 50322(a)(1), substituted “Subject to subparagraph (D), each” for “Each”.

Subsec. (a)(3)(D). Pub. L. 115-123, § 50322(a)(2), added subpar. (D).

Subsec. (m). Pub. L. 115-123, § 50323(a)(2), added subsec. (m).

Subsec. (n). Pub. L. 115-271 added subsec. (n).

2016—Subsec. (a)(1)(B)(i). Pub. L. 114-255, § 17006(c)(1), inserted “or coverage for organ acquisitions for kidney transplants, including as covered under section 1395rr(d) of this title” after “hospice care”.

Subsec. (b)(1). Pub. L. 114-255, § 17006(a)(2)(A), struck out subpar. (A) designation and heading, substituted “A Medicare Advantage organization” for “A Medicare+Choice organization”, and struck out subpar. (B). Prior to amendment, text of subpar. (B) read as follows: “Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1395w-21(a)(3)(B) of this title.”

2010—Subsec. (a)(1)(B)(i). Pub. L. 111-148, § 3202(a)(1)(A), inserted “, subject to clause (iii),” after “and B or”.

Subsec. (a)(1)(B)(iii) to (v). Pub. L. 111-148, § 3202(a)(1)(B), added cls. (iii) to (v).

2008—Subsec. (a)(7). Pub. L. 110-275, § 165(a), added par. (7).

Subsec. (d)(4). Pub. L. 110-275, § 162(a)(1)(A), (2)(A), in introductory provisions, substituted “Subject to paragraphs (5) and (6), the Secretary” for “The Secretary” in second sentence.

Subsec. (d)(4)(B). Pub. L. 110-275, § 162(a)(3)(A), substituted “a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1)” for “a sufficient number and range of providers within such category to provide covered services under the terms of the plan”.

Subsec. (d)(5). Pub. L. 110-275, § 162(a)(1)(B), added par. (5).

Subsec. (d)(6). Pub. L. 110-275, § 162(a)(2)(B), added par. (6).

Subsec. (e)(1). Pub. L. 110-275, § 163(a), struck out “(other than an MA private fee-for-service plan or an MSA plan)” before period at end.

Subsec. (e)(3)(A)(i). Pub. L. 110-275, § 163(b)(1), inserted at end “With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.”

Subsec. (e)(3)(A)(ii). Pub. L. 110-275, §§ 163(b)(2), 164(f)(1), added cl. (ii) and struck out former cl. (ii).

Prior to amendment, text read as follows: “The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.”

Subsec. (e)(3)(A)(iii). Pub. L. 110-275, §163(b)(3), inserted “local” after “to” and “and MA regional plans” after “organizations” in heading and “and to MA regional plans” after “organization plans” in text.

Subsec. (e)(4)(C). Pub. L. 110-275, §125(b)(6), substituted “section 1395bb(a)(2)” for “section 1395bb(b)(2)”.

2003—Subsec. (a)(1). Pub. L. 108-173, §222(a)(2), substituted “Requirement” for “In general” in par. heading, designated existing provisions as subpar. (A), inserted heading, substituted “chapter, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1395w-24(f)(1)(A) of this title)” for “chapter—”, added subpar. (B), and struck out former subpars. (A) and (B) which read as follows:

“(A) those items and services (other than hospice care) for which benefits are available under parts A and B of this subchapter to individuals residing in the area served by the plan, and

“(B) additional benefits required under section 1395w-24(f)(1)(A) of this title.”

Pub. L. 108-173, §221(d)(3)(A), inserted “and except as provided in paragraph (6) for MA regional plans” after “MSA plans” in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 108-173, §948(b)(2), substituted “determination” for “policy” wherever appearing in heading and text.

Subsec. (a)(3)(C). Pub. L. 108-173, §222(a)(3), inserted at end “Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1395w-24(e)(4)(B) of this title.”

Subsec. (a)(5). Pub. L. 108-173, §900(e)(1)(F), substituted “Centers for Medicare & Medicaid Services” for “Health Care Financing Administration” in concluding provisions.

Subsec. (a)(6). Pub. L. 108-173, §221(d)(3)(B), added par. (6).

Subsec. (b)(1)(A). Pub. L. 108-173, §222(l)(1), inserted at end “The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.”

Subsec. (c)(1)(I). Pub. L. 108-173, §722(b), amended heading and text of subpar. (I) generally. Prior to amendment, text read as follows: “A description of the organization’s quality assurance program under subsection (e) of this section, if required under such section.”

Pub. L. 108-173, §233(a)(2)(A), inserted “, if required under such section” before period at end.

Subsec. (d)(4). Pub. L. 108-173, §211(j)(2), inserted before period at end of concluding provisions “, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan”.

Subsec. (d)(4)(B). Pub. L. 108-173, §211(j)(1), inserted “(other than deemed contracts or agreements under subsection (j)(6))” after “the plan has contracts or agreements”.

Subsec. (e). Pub. L. 108-173, §722(a)(1), substituted “improvement” for “assurance” in heading.

Subsec. (e)(1). Pub. L. 108-173, §722(a)(2), reenacted heading without change and amended text generally.

Prior to amendment, text read as follows: “Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans (other than MSA plans) of the organization.”

Pub. L. 108-173, §233(a)(1), inserted “(other than MSA plans)” after “plans”.

Subsec. (e)(2). Pub. L. 108-173, §722(a)(2), amended par. (2) generally, substituting provisions relating to chronic care improvement programs for provisions relating to elements of the quality assurance program of an organization with respect to a Medicare+Choice plan.

Subsec. (e)(2)(A). Pub. L. 108-173, §233(a)(2)(B), struck out “, a non-network MSA plan,” after “fee-for-service plan” in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 108-173, §233(a)(2)(C), struck out “, non-network MSA plans,” after “fee-for-service plans” in heading and “, a non-network MSA plan,” after “fee-for-service plan” in introductory provisions.

Subsec. (e)(3). Pub. L. 108-173, §722(a)(2), amended par. (3) generally, substituting provisions relating to collection, analysis, and reporting of data for provisions relating to external review by an independent quality review and improvement organization.

Subsec. (e)(4)(B)(i). Pub. L. 108-173, §722(a)(3)(A), amended cl. (i) generally. Prior to amendment, cl. (i) read as follows: “Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).”

Subsec. (e)(4)(B)(vii). Pub. L. 108-173, §722(a)(3)(B), added cl. (vii).

Subsec. (e)(5). Pub. L. 108-173, §722(a)(4), struck out par. (5), which related to report to be submitted to Congress not later than 2 years after Dec. 21, 2000, and biennially thereafter, regarding how quality assurance programs focus on racial and ethnic minorities.

Subsec. (g)(5). Pub. L. 108-173, §940(b)(2)(A), inserted at end “The provisions of section 1395ff(b)(1)(E)(iii) of this title shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1395ff(b)(1)(E)(i) of this title.”

Subsec. (j)(4)(A). Pub. L. 108-173, §222(h)(1), inserted “the organization provides assurances satisfactory to the Secretary that” after “unless” in introductory provisions.

Subsec. (j)(4)(A)(ii). Pub. L. 108-173, §222(h)(2), substituted “the organization” for “the organization—”, struck out subcl. (I) designation before “provides”, substituted period for “, and” at end of subcl. (I), and struck out subcl. (II), which read as follows: “conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.”

Subsec. (j)(4)(A)(iii). Pub. L. 108-173, §222(h)(3), struck out cl. (iii) which read as follows: “The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.”

Subsec. (j)(7). Pub. L. 108-173, §102(b), added par. (7).

Subsec. (k)(1). Pub. L. 108-173, §233(c), inserted “or with an organization offering an MSA plan” after “section 1395w-21(a)(2)(A) of this title”.

2000—Subsec. (a)(2)(C). Pub. L. 106-554, §1(a)(6) [title VI, §615], added subpar. (C).

Subsec. (a)(5). Pub. L. 106-554, §1(a)(6) [title VI, §611(b)(5)], inserted concluding provisions.

Pub. L. 106-554, §1(a)(6) [title VI, §611(b)(1), (2)], inserted “and legislative changes in benefits” after “National coverage determinations” in heading and inserted “or legislative change in benefits required to be provided under this part” after “there is a national coverage determination” in introductory provisions.

Subsec. (a)(5)(A). Pub. L. 106-554, §1(a)(6) [title VI, §611(b)(3)], inserted “or legislative change in benefits” after “such determination”.

Subsec. (a)(5)(B). Pub. L. 106-554, §1(a)(6) [title VI, §611(b)(4)], inserted “or legislative change” after “if such coverage determination”.

Subsec. (e)(2)(A), (B). Pub. L. 106-554, §1(a)(6) [title VI, §616(a)], inserted concluding provisions.

Subsec. (e)(5). Pub. L. 106-554, §1(a)(6) [title VI, §616(b)], added par. (5).

Subsec. (g)(4). Pub. L. 106-554, §1(a)(6) [title V, §521(b)], inserted at end “The provisions of section 1395ff(c)(5) of this title shall apply to independent outside entities under contract with the Secretary under this paragraph.”

Subsec. (l). Pub. L. 106-554, §1(a)(6) [title VI, §621(a)], added subsec. (l).

1999—Subsec. (a)(3)(A). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(i)], struck out comma after “MSA plan” and inserted comma after “the coverage”.

Subsec. (e)(2)(A). Pub. L. 106-113, §1000(a)(6) [title V, §520(a)(1)], substituted “, a non-network MSA plan, or a preferred provider organization plan” for “or a non-network MSA plan” in introductory provisions.

Subsec. (e)(2)(B). Pub. L. 106-113, §1000(a)(6) [title V, §520(a)(2)], substituted “, non-network MSA plans, and preferred provider organization plans” for “and non-network MSA plans” in heading and “, a non-network MSA plan, or a preferred provider organization plan” for “or a non-network MSA plan” in introductory provisions.

Subsec. (e)(2)(D). Pub. L. 106-113, §1000(a)(6) [title V, §520(a)(3)], added subpar. (D).

Subsec. (e)(4). Pub. L. 106-113, §1000(a)(6) [title V, §518], amended heading and text of par. (4) generally. Prior to amendment, text read as follows: “The Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements of paragraphs (1) and (2) of this subsection and subsection (h) of this section (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1395w-26 of this title to carry out the respective requirements.”

Subsec. (g)(1)(B). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(i)(I)], inserted “or” after “in whole”.

Subsec. (g)(3)(B)(ii). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(ii)(II)], inserted period at end.

Subsec. (h)(2). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(iii)], substituted a semicolon for a comma before “and”.

Subsec. (k)(2)(C)(ii). Pub. L. 106-113, §1000(a)(6) [title III, §321(k)(6)(B)(iv)], substituted “balance” for “balancing” before “billing under subparagraph (A) could” in introductory provisions.

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108-173, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by section 17006(a)(2)(A) of Pub. L. 114-255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(a)(3) of Pub. L. 114-255, set out as a note under section 1395w-21 of this title.

Amendment by section 17006(c)(1) of Pub. L. 114-255 applicable with respect to plan years beginning on or after Jan. 1, 2021, see section 17006(c)(3) of Pub. L. 114-255, set out as a note under section 1395w-21 of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111-148, title III, §3202(a)(2), Mar. 23, 2010, 124 Stat. 454, provided that: “The amendments made by this subsection [amending this section] shall apply to plan years beginning on or after January 1, 2011.”

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by section 125(b)(6) of 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 an Effective Date of 2008 Amendment; Transition Rule note under section 1395bb of this title.

Pub. L. 110-275, title I, §162(a)(3)(B), July 15, 2008, 122 Stat. 2571, provided that: “The amendment made by subparagraph (A) [amending this section] shall apply to plan year 2010 and subsequent plan years.”

Pub. L. 110-275, title I, §163(c), July 15, 2008, 122 Stat. 2571, provided that: “The amendments made by this section [amending this section] shall apply to plan years beginning on or after January 1, 2010.”

Pub. L. 110-275, title I, §164(f)(2), July 15, 2008, 122 Stat. 2575, provided that: “The amendment made by paragraph (1) [amending this section] shall take effect on a date specified by the Secretary of Health and Human Services (but in no case later than January 1, 2010), and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq.]”

Pub. L. 110-275, title I, §165(b), July 15, 2008, 122 Stat. 2575, provided that: “The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2010.”

EFFECTIVE AND TERMINATION DATES OF 2003 AMENDMENT

Amendment by sections 221(d)(3) and 222(a)(2), (3), (h), (l)(1) of Pub. L. 108-173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108-173, set out as an Effective Date of 2003 Amendment note under section 1395w-21 of this title.

Pub. L. 108-173, title II, §233(a)(3), Dec. 8, 2003, 117 Stat. 2209, provided that: “The amendments made by this subsection [amending this section] shall apply on and after the date of the enactment of this Act [Dec. 8, 2003] but shall not apply to contract years beginning on or after January 1, 2006.”

Pub. L. 108-173, title VII, §722(c), Dec. 8, 2003, 117 Stat. 2348, provided that: “The amendments made by this section [amending this section] shall apply with respect to contract years beginning on and after January 1, 2006.”

Amendment by section 948(b)(2) of Pub. L. 108-173 effective, except as otherwise provided, as if included in the enactment of BIPA (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106-554), see section 948(e) of Pub. L. 108-173, set out as an Effective Date of 2003 Amendment note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title V, §521(b)] of Pub. L. 106-554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, §521(d)] of Pub. L. 106-554, set out as a note under section 1320c-3 of this title.

Pub. L. 106-554, §1(a)(6) [title VI, §611(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-560, provided that: “The amendments made by this section [amending this section and section 1395w-23 of this title] are effective on the date of the enactment of this Act [Dec. 21, 2000] and shall apply to national coverage determinations and legislative changes in benefits occurring on or after such date.”

Pub. L. 106-554, §1(a)(6) [title VI, §621(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-565, provided that: “The amendment made by subsection (a) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 21, 2000].”

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, §321(k)(6)(B)] of Pub. L. 106-113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106-113, set out as a note under section 1395d of this title.

Pub. L. 106-113, div. B, §1000(a)(6) [title V, §520(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-386, provided that: "The amendments made by subsection (a) [amending this section] apply to contract years beginning on or after January 1, 2000."

MEDPAC STUDY

Pub. L. 106-554, §1(a)(6) [title VI, §621(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A-565, provided that:

"(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study analyzing the effects of the amendment made by subsection (a) [amending this section] on Medicare+Choice organizations. In conducting such study, the Commission shall examine the effects (if any) such amendment has had—

"(A) on the scope of additional benefits provided under the Medicare+Choice program;

"(B) on the administrative and other costs incurred by Medicare+Choice organizations; and

"(C) on the contractual relationships between such organizations and skilled nursing facilities.

"(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1)."

TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000

Pub. L. 106-113, div. B, §1000(a)(6) [title II, §227(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-355, provided that: "The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w-22(a)(5)) shall apply with respect to the coverage of additional benefits for immunosuppressive drugs under the amendments made by this section [amending sections 1395k and 1395x of this title] for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A)."

§ 1395w-23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w-27 of this title and subject to subsections (e), (g), (i), and (l) and section 1395w-28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) Payment before 2006

For years before 2006, the payment amount shall be equal to ½ of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1395w-24(f)(1)(E) of this title.

(ii) Payment for original fee-for-service benefits beginning with 2006

For years beginning with 2006, the amount specified in subparagraph (B).

(B) Payment amount for original fee-for-service benefits beginning with 2006

(i) Payment of bid for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) Payment of benchmark for plans with bids at or above benchmark

In the case of a plan for which there are no average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) Payment of benchmark for MSA plans

Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(iv) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals

(I) In general

Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1395eee(d) of this title (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) Plan described

A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1395w-28(b)(6)(B)(ii) of this title that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.