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 administration 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, ac-

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

curate, 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 employment were covered employment under such subchapter) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

(Aug. 14, 1935, ch. 531, title XVIII, § 1811, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291; amended Pub. L. 92–603, title II, § 201(a)(2), Oct. 30, 1972, 86 Stat. 1371; Pub. L. 95–292, § 4(a), June 13, 1978, 92 Stat. 315; Pub. L. 96–265, title I, § 103(a)(2), June 9, 1980, 94 Stat. 444; Pub. L. 96–473, § 2(b), Oct. 19, 1980, 94 Stat. 2263; Pub. L. 96–499, title IX, § 930(a), Dec. 5, 1980, 94 Stat. 2631; Pub. L. 97–248, title I, § 122(a)(1), title II, § 278(b)(3), Sept. 3, 1982, 96 Stat. 356, 561; Pub. L. 99–272, title XIII, § 13205(b)(2)(C)(i), Apr. 7, 1986, 100 Stat. 317; Pub. L. 100–360, title I, § 104(d)(1), July 1, 1988, 102 Stat. 688; Pub. L. 101–234, title I, § 101(a), Dec. 13, 1989, 103 Stat. 1979.)

AMENDMENTS

1989—Pub. L. 101–234 repealed Pub. L. 100–360, § 104(d)(1), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

1988—Pub. L. 100–360 substituted ''inpatient hospital services, extended care services'' for ''hospital, related post-hospital''.

1986—Pub. L. 99–272 substituted ''government employment'' for ''Federal employment'' in cls. (1) and (2).

1982—Pub. L. 97–248, § 122(a)(1), substituted ''home health services, and hospice care'' for ''and home health services''.

Pub. L. 97–248, § 278(b)(3), inserted ''(or would be eligible for such benefits if certain Federal employment were covered employment under such subchapter)'' after ''subchapter II of this chapter'' in cl. (1), and inserted ''(or would have been so entitled to such benefits if certain Federal employment were covered employment under such subchapter)'' after ''subchapter II of this chapter'' in cl. (2).

1980—Pub. L. 96–499 substituted '', related post-hospital, and home health services'' for ''and related post-hospital services''.

Pub. L. 96–473 substituted ''are eligible for'' for ''are entitled to''.

Pub. L. 96–265 substituted ''not less than 24 months'' for ''not less than 24 consecutive months''.

1978—Pub. L. 95–292 inserted references to section 426–1 of this title and to individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

1972—Pub. L. 92–603 designated existing provisions as cl. (1) and added cl. (2).

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–234, title I, § 101(d), Dec. 13, 1989, 103 Stat. 1980, provided that: ''The provisions of this section [amending this section and sections 1395d, 1395e, 1395f, 1395k, 1395x, 1395cc, and 1395tt of this title, enacting provisions set out as notes under sections 1395e and 1395ww of this title, and amending provisions set out as notes under sections 1395e and 1395ww of this title] shall take effect January 1, 1990, except that the