

“(a) **ESTABLISHMENT.**—Within one year after the date of the enactment of this Act [July 15, 2008], the Secretary (in this section referred to as the ‘Secretary’) shall establish a demonstration project to determine the greatest needs and most effective methods of outreach to medicare beneficiaries who were previously uninsured.

“(b) **SCOPE.**—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq., 1395w-21 et seq.]. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the ‘Welcome to Medicare’ physical exam.

“(c) **DURATION.**—The Secretary shall conduct the demonstration project for a period of 2 years.

“(d) **REPORT AND EVALUATION.**—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

“(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

“(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.”

#### STATE REGULATORY PROGRAMS

For provisions relating to changes required to conform State regulatory programs to amendments by section 171 of Pub. L. 103-432, see section 171(m) of Pub. L. 103-432, set out as a note under section 1395ss of this title.

### § 1395b-5. Beneficiary incentive programs

**(a) Repealed. Pub. L. 105-33, title IV, § 4311(b)(2), Aug. 5, 1997, 111 Stat. 386**

**(b) Program to collect information on fraud and abuse**

#### (1) Establishment of program

Not later than 3 months after August 21, 1996, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging in or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1320a-7, 1320a-7a, or 1320a-7b of this title, or who have otherwise engaged in fraud and abuse against the Medicare program under this subchapter for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

#### (2) Payment of portion of amounts collected

If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least \$100 (other than any amount paid as a penalty under section 1320a-7b of this title), the Sec-

retary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

**(c) Program to collect information on program efficiency**

#### (1) Establishment of program

Not later than 3 months after August 21, 1996, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the Medicare program.

#### (2) Payment of portion of program savings

If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

(Pub. L. 104-191, title II, § 203, Aug. 21, 1996, 110 Stat. 1998; Pub. L. 105-33, title IV, § 4311(b)(2), Aug. 5, 1997, 111 Stat. 386.)

#### REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(2), is classified generally to Title 26, Internal Revenue Code.

#### CODIFICATION

Section was enacted as part of the Health Insurance Portability and Accountability Act of 1996, and not as part of the Social Security Act which comprises this chapter.

#### AMENDMENTS

1997—Subsec. (a). Pub. L. 105-33 struck out heading and text of subsec. (a). Text read as follows: “The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall provide an explanation of benefits under the Medicare program under this subchapter with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.”

### § 1395b-6. Medicare Payment Advisory Commission

**(a) Establishment**

There is hereby established as an agency of Congress the Medicare Payment Advisory Commission (in this section referred to as the “Commission”).

**(b) Duties**

#### (1) Review of payment policies and annual reports

The Commission shall—

(A) review payment policies under this subchapter, including the topics described in paragraph (2);

(B) make recommendations to Congress concerning such payment policies;

(C) by not later than March 15,<sup>1</sup> submit a report to Congress containing the results of

<sup>1</sup> So in original.

such reviews and its recommendations concerning such policies; and

(D) by not later than June 15 of each year, submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program and including a review of the estimate of the conversion factor submitted under section 1395w-4(d)(1)(E)(ii) of this title, and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible.

**(2) Specific topics to be reviewed**

**(A) Medicare+Choice program**

Specifically, the Commission shall review, with respect to the Medicare+Choice program under part C, the following:

(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

(iii) The implications of risk selection both among Medicare+Choice organizations and between the Medicare+Choice option and the original medicare fee-for-service option.

(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare+Choice organizations.

(v) The impact of the Medicare+Choice program on access to care for medicare beneficiaries.

(vi) Other major issues in implementation and further development of the Medicare+Choice program.

**(B) Original medicare fee-for-service system**

Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for the efficient provision of services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

(ii) payment methodologies, and

(iii) their relationship to access and quality of care for medicare beneficiaries.

**(C) Interaction of medicare payment policies with health care delivery generally**

Specifically, the Commission shall review the effect of payment policies under this subchapter on the delivery of health care services other than under this subchapter and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

**(3) Comments on certain secretarial reports**

If the Secretary submits to Congress (or a committee of Congress) a report that is re-

quired by law and that relates to payment policies under this subchapter, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

**(4) Agenda and additional reviews**

The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this subchapter as may be requested by such chairmen and members and as the Commission deems appropriate.

**(5) Availability of reports**

The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

**(6) Appropriate committees of Congress**

For purposes of this section, the term "appropriate committees of Congress" means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

**(7) Voting and reporting requirements**

With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

**(8) Examination of budget consequences**

Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

**(9) Review and annual report on Medicaid and commercial trends**

The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under subchapter XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1396 of this title (in this section referred to as "MACPAC").

**(10) Coordinate and consult with the Federal Coordinated Health Care Office**

The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081<sup>2</sup> of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

**(11) Interaction of Medicaid and Medicare**

The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.

**(c) Membership**

**(1) Number and appointment**

The Commission shall be composed of 17 members appointed by the Comptroller General.

**(2) Qualifications**

**(A) In general**

The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

**(B) Inclusion**

The membership of the Commission shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

**(C) Majority nonproviders**

Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this subchapter shall not constitute a majority of the membership of the Commission.

**(D) Ethical disclosure**

The Comptroller General shall establish a system for public disclosure by members of

the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

**(3) Terms**

**(A) In general**

The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

**(B) Vacancies**

Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

**(4) Compensation**

While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

**(5) Chairman; Vice Chairman**

The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

**(6) Meetings**

The Commission shall meet at the call of the Chairman.

**(d) Director and staff; experts and consultants**

Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

- (1) employ and fix the compensation of an Executive Director (subject to the approval of

<sup>2</sup> See References in Text note below.

the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5 governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 6101 of title 41);

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

**(e) Powers**

**(1) Obtaining official data**

The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

**(2) Data collection**

In order to carry out its functions, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

**(3) Access of GAO to information**

The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

**(4) Periodic audit**

The Commission shall be subject to periodic audit by the Comptroller General.

**(f) Authorization of appropriations**

**(1) Request for appropriations**

The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

**(2) Authorization**

There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of

such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(Aug. 14, 1935, ch. 531, title XVIII, § 1805, as added Pub. L. 105-33, title IV, § 4022(a), Aug. 5, 1997, 111 Stat. 350; amended Pub. L. 105-277, div. J, title V, § 5202(a), Oct. 21, 1998, 112 Stat. 2681-917; Pub. L. 106-113, div. B, § 1000(a)(6) [title II, § 211(a)(2)(B)], Nov. 29, 1999, 113 Stat. 1536, 1501A-347; Pub. L. 106-554, § 1(a)(6) [title V, § 544(a)(1), (b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-551; Pub. L. 108-173, title VII, § 735(a)-(c)(1), (e)(1), Dec. 8, 2003, 117 Stat. 2353, 2354; Pub. L. 110-173, title III, § 301, Dec. 29, 2007, 121 Stat. 2514; Pub. L. 111-148, title II, § 2801(b), title III, § 3403(c), Mar. 23, 2010, 124 Stat. 332, 507; Pub. L. 115-123, div. E, title XI, § 52001(b)(3), Feb. 9, 2018, 132 Stat. 298.)

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in subsec. (b)(10), is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. The Act does not contain a section 2081. The Federal Coordinated Health Care Office is established in section 2602(a)(1) of the Act, which is classified to section 1315b(a)(1) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Ethics in Government Act of 1978, referred to in subsec. (c)(2)(D), is Pub. L. 95-521, Oct. 26, 1978, 92 Stat. 1824. Title I of the Act is set out in the Appendix to Title 5, Government Organization and Employees. For complete classification of this Act to the Code, see Short Title note set out under section 101 of Pub. L. 95-521 in the Appendix to Title 5 and Tables.

CODIFICATION

In subsec. (d)(3), “section 6101 of title 41” substituted for “section 3709 of the Revised Statutes (41 U.S.C. 5)” on authority of Pub. L. 111-350, § 6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2018—Subsec. (b)(4) to (9). Pub. L. 115-123 struck out par. (4), redesignated former pars. (5) to (8) as (4) to (7), respectively, and redesignated former par. (9) relating to examination of budget consequences as par. (8). Prior to amendment, par. (4) related to review and comment on proposals submitted to the Commission.

2010—Subsec. (b)(1)(C). Pub. L. 111-148, § 2801(b)(1), substituted “March 15” for “March 1 of each year (beginning with 1998)”.

Subsec. (b)(1)(D). Pub. L. 111-148, § 2801(b)(2), inserted “, and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible” before the period.

Subsec. (b)(4). Pub. L. 111-148, § 3403(c)(2), added par. (4). Former par. (4) redesignated (5).

Subsec. (b)(5) to (8). Pub. L. 111-148, § 3403(c)(1), redesignated pars. (4) to (7) as (5) to (8), respectively. Former par. (8) relating to examination of budget consequences redesignated (9).

Subsec. (b)(9). Pub. L. 111-148, § 3403(c)(1), redesignated par. (8) relating to examination of budget consequences as (9).

Pub. L. 111-148, § 2801(b)(3), added par. (9) relating to review and annual report on Medicaid and commercial trends.

Subsec. (b)(10), (11). Pub. L. 111-148, § 2801(b)(3), added pars. (10) and (11).

2007—Subsec. (a). Pub. L. 110-173 inserted “as an agency of Congress” after “established”.

2003—Subsec. (b)(2)(B)(i). Pub. L. 108-173, § 735(b), inserted “the efficient provision of” after “expenditures for”.

Subsec. (b)(8). Pub. L. 108-173, §735(a), added par. (8).  
 Subsec. (c)(2)(B). Pub. L. 108-173, §735(e)(1), inserted “experts in the area of pharmaco-economics or prescription drug benefit programs,” after “other health professionals.”

Subsec. (c)(2)(D). Pub. L. 108-173, §735(c)(1), inserted at end “Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).”

2000—Subsec. (b)(1)(D). Pub. L. 106-554, §1(a)(6) [title V, §544(a)(1)], substituted “June 15 of each year,” for “June 1 of each year (beginning with 1998).”

Subsec. (b)(7). Pub. L. 106-554, §1(a)(6) [title V, §544(b)], added par. (7).

1999—Subsec. (b)(1)(D). Pub. L. 106-113 inserted “and including a review of the estimate of the conversion factor submitted under section 1395w-4(d)(1)(E)(ii) of this title” before period at end.

1998—Subsec. (c)(1). Pub. L. 105-277 substituted “17” for “15”.

#### 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 2003 AMENDMENT

Pub. L. 108-173, title VII, §735(c)(2), Dec. 8, 2003, 117 Stat. 2354, provided that: “The amendment made by paragraph (1) [amending this section] shall take effect on January 1, 2004.”

#### EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106-554, §1(a)(6) [title V, §544(a)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A-551, provided that: “The amendment made by paragraph (1) [amending this section] shall apply beginning with 2001.”

#### EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by Pub. L. 106-113 effective in determining conversion factor under section 1395w-4(d) of this title for years beginning with 2001 and not applicable to or affecting any update (or any update adjustment factor) for any year before 2001, see section 1000(a)(6) [title II, §211(d)] of Pub. L. 106-113, set out as a note under section 1395w-4 of this title.

#### EFFECTIVE DATE; TRANSITION; TRANSFER OF FUNCTIONS

Pub. L. 105-33, title IV, §4022(c), Aug. 5, 1997, 111 Stat. 355, provided that:

“(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ‘MedPAC’) by not later than September 30, 1997.

“(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed [Oct. 1, 1997, see 62 FR 52131], the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ‘ProPAC’) and the Physician Payment Review Commission (in this subsection referred to as ‘PPRC’), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions [Nov. 1, 1997, see 62 FR 59356], the amendments made by paragraphs (1) and (2), respectively, of subsection (b) [amending sections 1395w-4, 1395y, and 1395ww of this title and repealing section 1395w-1 of this title] become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

“(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.”

#### APPOINTMENT OF EXPERTS IN PRESCRIPTION DRUGS

Pub. L. 108-173, title VII, §735(e)(2), Dec. 8, 2003, 117 Stat. 2354, provided that: “The Comptroller General of the United States shall ensure that the membership of the Commission [Medicare Payment Advisory Commission] complies with the amendment made by paragraph (1) [amending this section] with respect to appointments made on or after the date of the enactment of this Act [Dec. 8, 2003].”

#### MEDPAC ANALYSIS OF IMPACT OF VOLUME ON PER UNIT COST OF RURAL HOSPITALS WITH PSYCHIATRIC UNITS

Pub. L. 106-554, §1(a)(6) [title II, §214], Dec. 21, 2000, 114 Stat. 2763, 2763A-486, provided that: “The Medicare Payment Advisory Commission, in its study conducted pursuant to subsection (a) of section 411 of BBRA [Pub. L. 106-113, §1000(a)(6) [title IV, §411], set out as a note below] (113 Stat. 1501A-377), shall include—

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

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

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

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

“(1) STUDY.—The Medicare Payment Advisory Commission shall undertake a comprehensive study to review the regulatory burdens placed on all classes of health care providers under parts A and B of the medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and to determine the costs these burdens impose on the nation’s health care system. The study shall also examine the complexity of the current regulatory system and its impact on providers.

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

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

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

#### MEDPAC REPORT

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

#### MEDPAC STUDY OF RURAL PROVIDERS

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

“(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of rural providers fur-

nishing items and services for which payment is made under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.]. Such study shall examine and evaluate the adequacy and appropriateness of the categories of special payments (and payment methodologies) established for rural hospitals under the medicare program, and the impact of such categories on beneficiary access and quality of health care services.

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

#### QUALITY IMPROVEMENT STANDARDS

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

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

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

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

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

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

#### INITIAL TERMS OF ADDITIONAL MEMBERS

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

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

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

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

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

#### INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS

Pub. L. 105-33, title IV, §4804(c), Aug. 5, 1997, 111 Stat. 552, provided that: “The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act [42 U.S.C. 1395b-6(b)(1)(B)] recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act [42 U.S.C. 1395eee(d), 1396u-4(d)] and on the treatment of private, for-profit entities as PACE providers.”

### § 1395b-7. Explanation of medicare benefits

#### (a) In general

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

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

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

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

##### (1) In general

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

##### (2) 30-day period to furnish statement

###### (A) In general

Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describing each item or service provided to the individual requesting the itemized statement.

###### (B) Penalty

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

##### (3) Review of itemized statement

###### (A) In general

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

###### (B) Specific allegations

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

- (i) specific items or services that the individual believes were not provided as claimed, or
- (ii) any other billing irregularity (including duplicate billing).

##### (4) Findings of Secretary

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

##### (5) Recovery of amounts

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

#### (c) Format of statements from Secretary

##### (1) Electronic option beginning in 2016

Subject to paragraph (2), for statements described in subsection (a) that are furnished for