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.''

MEDPAC REVIEW OF PAYMENTS TO RURAL EMERGENCY HOSPITALS

Pub. L. 116–260, div. CC, title I, §125(f), Dec. 27, 2020, 134 Stat. 2966, provided that: ''Each report submitted by the Medicare Payment Advisory Commission under section 1805(b)(1)(C) of the Social Security Act (42 U.S.C. 1395b–6(b)(1)(C)) (beginning with 2024), shall include a review of payments to rural emergency hospitals under section 1834(x) [42 U.S.C. 1395m(x)], as added by subsection (a).''

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, required a comprehensive study related to regulatory burdens placed on health care providers and, no later than Dec. 31, 2001, a report and legislative recommendations.

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, required a study evaluating the adequacy and appropriateness of the categories of special payments established for rural hospitals under the medicare program and a report to be submitted no later than 18 months after Nov. 29, 1999.

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 a period in 2016 or a subsequent year, in the case that an individual described in subsection (a) elects, in accordance with such form, manner, and time specified by the Secretary, to receive such statement in an electronic format, such statement shall be furnished to such individual for each period subsequent to such election in such a format and shall not be mailed to the individual.

(2) Limitation on revocation option

(A) In general

Subject to subparagraph (B), the Secretary may determine a maximum number of elections described in paragraph (1) by an individual that may be revoked by the individual.

(B) Minimum of one revocation option

In no case may the Secretary determine a maximum number under subparagraph (A) that is less than one.

(3) Notification

The Secretary shall ensure that, in the most cost effective manner and beginning January 1, 2017, a clear notification of the option to elect to receive statements described in subsection (a) in an electronic format is made available, such as through the notices distributed under section 1395b–2 of this title, to individuals described in subsection (a).

(Aug. 14, 1935, ch. 531, title XVIII, § 1806, as added Pub. L. 105–33, title IV, § 4311(b)(1), Aug. 5, 1997, 111 Stat. 385; amended Pub. L. 114–10, title V, § 508(a), Apr. 16, 2015, 129 Stat. 169.)

AMENDMENTS

2015—Subsec. (c). Pub. L. 114–10 added subsec. (c).

EFFECTIVE DATE

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

''(A) STATEMENT BY SECRETARY.—Paragraph (1) of section 1806(a) of the Social Security Act [42 U.S.C. 1395b–7(a)(1)], as added by paragraph (1), and the repeal made by paragraph (2) [amending section 1395b–5 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997].

''(B) ITEMIZED STATEMENT.—Paragraph (2) of section 1806(a) and section 1806(b) of the Social Security Act [42 U.S.C. 1395b–7(a)(2), (b)], as so added, shall take effect not later than January 1, 1999.''

ENCOURAGED EXPANSION OF ELECTRONIC STATEMENTS

Pub. L. 114–10, title V, § 508(b), Apr. 16, 2015, 129 Stat. 169, provided that: ''To the extent to which the Secretary of Health and Human Services determines appropriate, the Secretary shall—

''(1) apply an option similar to the option described in subsection (c)(1) of section 1806 of the Social Security Act (42 U.S.C. 1395b–7) (relating to the provision of the Medicare Summary Notice in an electronic format), as added by subsection (a), to other statements and notifications under title XVIII of such Act (42 U.S.C. 1395 et seq.); and

''(2) provide such Medicare Summary Notice and any such other statements and notifications on a more frequent basis than is otherwise required under such title.''

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

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

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

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

§ 1395b–8. Chronic care improvement

(a) Implementation of chronic care improvement programs

(1) In general

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

(2) Definitions

For purposes of this section:

(A) Chronic care improvement program

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

(B) Chronic care improvement organization

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

(C) Care management plan

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

(D) Threshold condition

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

(E) Targeted beneficiary

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

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

(ii) has one or more threshold conditions covered under such program; and

(iii) has been identified under subsection (d)(1) as a potential participant in such program.

(3) Construction

Nothing in this section shall be construed as—

(A) expanding the amount, duration, or scope of benefits under this subchapter;

(B) providing an entitlement to participate in a chronic care improvement program under this section;

(C) providing for any hearing or appeal rights under section 1395ff, 1395*oo* of this title, or otherwise, with respect to a chronic care improvement program under this section; or

(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1395x(d) of this title).

(b) Developmental phase (Phase I)

(1) In general

In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after December 8, 2003.

(2) Agreement period

The period of an agreement under this subsection shall be for 3 years.

(3) Minimum participation

(A) In general

The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

(B) Medicare beneficiary defined

In this paragraph, the term ''medicare beneficiary'' means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

(4) Site selection

In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

(5) Independent evaluations of Phase I programs

The Secretary shall contract for an independent evaluation of the programs conducted