§ 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, 1 submit a report to Congress containing the results of 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 of this subchapter, 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 of this subchapter, 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 required 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) **Review and comment on the Independent Payment Advisory Board or Secretarial proposal**

If the Independent Payment Advisory Board (as established under subsection (a) of section 1395kkk of this title) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.

(5) **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.

(6) **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.

(7) **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.

(8) **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.

(9) **2 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) **2 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 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

(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 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.

Footnotes
1 So in original.
2 So in original. Two pars. (9) have been enacted.
3 See References in Text note below.

(Aug. 14, 1935, ch. 531, title XVIII, § 1805, as added Pub. L. 105–33, title IV, § 4022(a), Aug. 5,
1536, 1501A–347; Pub. L. 106–554, § 1(a)(6) [title V, § 544(a)(1), (b)], Dec. 21, 2000, 114 Stat. 2763,
3403(c), title X, § 10320(b), Mar. 23, 2010, 124 Stat. 332, 507, 952.)

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.

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


Amendments


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


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).


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


Subsec. (c)(2)(B). Pub. L. 110–173, § 735(e)(1), inserted “experts in the area of pharmaco-economics or prescription drug benefit programs,” after “other health professionals,”.


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),”.


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.

“Independent Payment Advisory Board” substituted for “Independent Medicare Advisory Board” on authority of section 10320(b) of Pub. L. 111–148, set out as a note under section 1395kkk of this title.

Effective Date of 2003 Amendment


Effective Date of 2000 Amendment


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

Section 4022(c) of Pub. L. 105–33 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


MedPAC Analysis of Impact of Volume on Per Unit Cost of Rural Hospitals With Psychiatric Units


“(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


“(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 [this subchapter] 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

“(a) Study.—The Medicare Payment Advisory Commission shall conduct a study of rural providers furnishing items and services for which payment is made under title XVIII of the Social Security Act [this subchapter]. 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.) [parts A and B of this subchapter].

“(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

“(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
Section 4804(c) of Pub. L. 105–33 provided that: “The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act [subsec. (b)(1)(B) of this section] recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act [sections 1395eee (d) and 1396u–4 (d) of this title] and on the treatment of private, for-profit entities as PACE providers.”