(i) Limitation on review

There shall be no administrative or judicial review of any determination made by the Secretary under this section.

(Aug. 14, 1935, ch. 531, title XVIII, § 1897, as added Pub. L. 108–173, title X, § 1016, Dec. 8, 2003, 117 Stat. 2447; amended Pub. L. 109–13, div. A, title VI, § 6045(a), (b), May 11, 2005, 119 Stat. 294.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (c)(3)(A), is classified generally to Title 26, Internal Revenue Code.

The Higher Education Act of 1965, referred to in subsec. (f), is Pub. L. 89–329, Nov. 8, 1965, 79 Stat. 1219, as amended. Part D of title IV of the Act is classified to part C (§ 1087a et seq.) of subchapter IV of chapter 28 of Title 20, Education. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 20 and Tables.

AMENDMENTS

2005—Subsec. (c)(2). Pub. L. 109–13, § 6045(a)(1)(A), inserted ''or an entity described in paragraph (3)'' after ''means a hospital'' in introductory provisions.

Subsec. (c)(2)(B). Pub. L. 109–13, § 6045(a)(1)(B), inserted ''legislature'' after ''designated by the State'' and ''and such designation by the State legislature occurred prior to December 8, 2003'' before period at end.

Subsec. (c)(3). Pub. L. 109–13, § 6045(a)(2), added par. (3).

Subsec. (i). Pub. L. 109–13, § 6045(b), added subsec. (i).

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–13, div. A, title VI, § 6045(c), May 11, 2005, 119 Stat. 295, provided that: ''The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2447).''

§ 1395iii. Medicare Improvement Fund

(a) Establishment

The Secretary shall establish under this subchapter a Medicare Improvement Fund (in this section referred to as the ''Fund'') which shall be available to the Secretary to make improvements under the original medicare fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part A or enrolled under part B including, but not limited to, an increase in the conversion factor under section 1395w–4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program.

(b) Funding

(1) In general

There shall be available to the Fund, for expenditures from the Fund for services furnished during—

(A) fiscal year 2014, $0;

(B) fiscal year 2015, $275,000,000; and

(C) fiscal year 2020 and each subsequent fiscal year, the Secretary's estimate, as of July 1 of the fiscal year, of the aggregate reduction in expenditures under this subchapter during the preceding fiscal year directly resulting from the reduction in payment amounts under sections 1395w–4(a)(7), 1395w–23(*l*)(4), 1395w–23(m)(4), and 1395ww(b)(3)(B)(ix) of this title.

(2) Payment from Trust Funds

The amount specified under paragraph (1) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.

(3) Funding limitation

Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under paragraph (1). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

(4) No effect on payments in subsequent years

In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this subchapter for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.

(Aug. 14, 1935, ch. 531, title XVIII, § 1898, as added Pub. L. 110–252, title VII, § 7002(a), June 30, 2008, 122 Stat. 2394; amended Pub. L. 110–275, title I, § 188(a)(2)(B), July 15, 2008, 122 Stat. 2589; Pub. L. 110–379, § 6, Oct. 8, 2008, 122 Stat. 4079; Pub. L. 111–5, div. B, title IV, § 4103(b), Feb. 17, 2009, 123 Stat. 487; Pub. L. 111–118, div. B, § 1011(b), Dec. 19, 2009, 123 Stat. 3474; Pub. L. 111–148, title III, § 3112, Mar. 23, 2010, 124 Stat. 421; Pub. L. 111–309, title II, § 207, Dec. 15, 2010, 124 Stat. 3291.)

AMENDMENTS

2010—Subsec. (b)(1)(A). Pub. L. 111–148, which directed substitution of ''$0'' for ''$22,290,000,000'', was executed by making the substitution for ''$20,740,000,000'' to reflect the probable intent of Congress and the intervening amendment by Pub. L. 111–118, § 1011(b)(1)(A). See 2009 Amendment note below.

Subsec. (b)(1)(B). Pub. L. 111–309 substituted ''$275,000,000'' for ''$550,000,000''.

2009—Subsec. (a). Pub. L. 111–5, § 4103(b)(1), inserted ''medicare'' before ''fee-for-service program under'' and ''including, but not limited to, an increase in the conversion factor under section 1395w–4(d) of this title to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program'' before period at end.

Subsec. (b)(1). Pub. L. 111–5, § 4103(b)(2)(A), substituted ''during—'' for ''during fiscal year 2014, $2,290,000,000 and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000.'' and added subpars. (A) and (B).

Subsec. (b)(1)(A). Pub. L. 111–118, § 1011(b)(1)(A), substituted ''$20,740,000,000'' for ''$22,290,000,000''.

Subsec. (b)(1)(B), (C). Pub. L. 111–118, § 1011(b)(1)(B)–(3), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (b)(4). Pub. L. 111–5, § 4103(b)(2)(B), added par. (4).

2008—Subsec. (b)(1). Pub. L. 110–379 substituted ''$2,290,000,000'' for ''$2,220,000,000''.

Pub. L. 110–275 inserted ''and, in addition for services furnished during fiscal years 2014 through 2017, $19,900,000,000'' before period at end.

§ 1395jjj. Shared savings program

(a) Establishment

(1) [1] In general

Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ''program'') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ''ACO''); and

(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

(b) Eligible ACOs

(1) In general

Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

(A) ACO professionals in group practice arrangements.

(B) Networks of individual practices of ACO professionals.

(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

(D) Hospitals employing ACO professionals.

(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

(2) Requirements

An ACO shall meet the following requirements:

(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the ''agreement period'').

(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

(3) Quality and other reporting requirements

(A) In general

The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

(i) clinical processes and outcomes;

(ii) patient and, where practicable, caregiver experience of care; and

(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

(B) Reporting requirements

An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

(C) Quality performance standards

The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

(D) Other reporting requirements

The Secretary may, as the Secretary determines appropriate, incorporate reporting

[1] So in original. No par. (2) has been enacted.