

atives a report regarding implementation of this section [amending this section]. Thereafter, the Administrator shall notify such committees if any hospital terminates or fails to renew an agreement described in paragraph (1) for the reasons described in that paragraph.”

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103-7 (in which item 7 on page 96 identifies a report on “Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed” authorized by 42 U.S.C. 1395cc note), see section 3003 of Pub. L. 104-66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

Pub. L. 99-272, title IX, §9122(d), Apr. 7, 1986, 100 Stat. 167, provided that: “The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act [42 U.S.C. 1395cc] as a result of the additional conditions imposed under the amendments made by subsection (a) [amending this section].”

[For termination, effective May 15, 2000, of provisions of law requiring submittal to Congress of any annual, semiannual, or other regular periodic report listed in House Document No. 103-7 (in which item 7 on page 96 identifies a report on “Hospitals that have terminated or failed to renew an agreement under section 1866 of Social Security Act as a result of the additional conditions imposed” authorized by 42 U.S.C. 1395cc note), see section 3003 of Pub. L. 104-66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.]

DELAY IN IMPLEMENTATION OF REQUIREMENT THAT HOSPITALS MAINTAIN AGREEMENTS WITH UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION

Pub. L. 98-369, div. B, title III, §2347(b), July 18, 1984, 98 Stat. 1096, provided that: “Notwithstanding section 604(a)(2) of the Social Security Amendments of 1983 [section 604(a)(2) of Pub. L. 98-21, set out as an Effective Date of 1983 Amendment note under section 1395ww of this title], the requirement that a hospital maintain an agreement with a utilization and quality control peer review [now “quality improvement”] organization, as contained in section 1866(a)(1)(F) of the Social Security Act [42 U.S.C. 1395cc(a)(1)(F)], shall become effective on November 15, 1984.”

INTERIM WAIVER IN CERTAIN CASES OF BILLING RULE FOR ITEMS AND SERVICES OTHER THAN PHYSICIANS’ SERVICES

For authority to waive the requirements of subsec. (a)(1)(H) of this section for any cost period prior to Oct. 1, 1986, where immediate compliance would threaten the stability of patient care, see section 602(k) of Pub. L. 98-21, set out as a note under section 1395y of this title.

PRIVATE SECTOR REVIEW INITIATIVE

Pub. L. 97-248, title I, §119, Sept. 3, 1982, 96 Stat. 355, provided that:

“(a) The Secretary of Health and Human Services shall undertake an initiative to improve medical review by intermediaries and carriers under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and to encourage similar review efforts by private insurers and other private entities. The initiative shall include the development of specific standards for measuring the performance of such intermediaries and carriers with respect to the identification and reduction of unnecessary utilization of health services.

“(b) Where such review activity results in the denial of payment to providers of services under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], such providers shall be prohibited, in accordance with sections 1866 and 1879 of such title [42 U.S.C. 1395cc,

1395pp], from collecting any payments from beneficiaries unless otherwise provided under such title.”

AGREEMENTS FILED AND ACCEPTED PRIOR TO OCT. 30, 1972, DEEMED TO BE FOR SPECIFIED TERM ENDING DEC. 31, 1973

Pub. L. 92-603, title II, §249A(f), Oct. 30, 1972, 86 Stat. 1427, provided that: “Notwithstanding any other provision of law, any agreement, filed by a skilled nursing facility (as defined in section 1861(j) of the Social Security Act [42 U.S.C. 1395x(j)]) with the Secretary under section 1866 of such Act [42 U.S.C. 1395cc] and accepted by him prior to the date of enactment of this Act [Oct. 30, 1972], which was in effect on such date shall be deemed to be for a specified term ending on December 31, 1973.”

§ 1395cc-1. Demonstration of application of physician volume increases to group practices

(a) Demonstration program authorized

(1) In general

The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this subchapter that—

(A) encourage coordination of the care furnished to individuals under the programs under parts A and B of this subchapter by institutional and other providers, practitioners, and suppliers of health care items and services;

(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

(C) reward physicians for improving health outcomes.

Such projects shall focus on the efficiencies of furnishing health care in a group-practice setting as compared to the efficiencies of furnishing health care in other health care delivery systems.

(2) Administration by contract

Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1395cc-2 of this title.

(3) Definitions

For purposes of this section, terms have the following meanings:

(A) Physician

Except as the Secretary may otherwise provide, the term “physician” means any individual who furnishes services which may be paid for as physicians’ services under this subchapter.

(B) Health care group

The term “health care group” means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians’ services under this subchapter. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrangement structured

so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d) of this section.

(b) Eligibility criteria

(1) In general

The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

(2) Payment method

A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c) of this section)—

(A) to be paid on a fee-for-service basis; and

(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

(3) Data reporting

A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary requires, for purposes of monitoring and evaluation of the demonstration under this section.

(c) Patients within scope of demonstration

(1) In general

The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) of this section and for assessment of the effectiveness of the group in achieving the objectives of this section.

(2) Other criteria

The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

(3) Notice requirements

In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

(d) Incentives

(1) Performance target

The Secretary shall establish for each health care group participating in a demonstration under this section—

(A) a base expenditure amount, equal to the average total payments under parts A and B of this subchapter for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

(2) Incentive bonus

The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the medicare savings realized for such year relative to the performance target.

(3) Additional bonus for process and outcome improvements

At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this subchapter resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

(4) Limitation

The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this subchapter (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

(Aug. 14, 1935, ch. 531, title XVIII, §1866A, as added Pub. L. 106-554, §1(a)(6) [title IV, §412(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-509.)

GAO REPORT

Pub. L. 106-554, §1(a)(6) [title IV, §412(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A-515, provided that: "Not later than 2 years after the date on which the demonstration project under section 1866A of the Social Security Act [42 U.S.C. 1395cc-1], as added by subsection (a), is implemented, the Comptroller General of the United States shall submit to Congress a report on such demonstration project. The report shall include such recommendations with respect to changes to the demonstration project that the Comptroller General determines appropriate."

§ 1395cc-2. Provisions for administration of demonstration program

(a) General administrative authority

(1) Beneficiary eligibility

Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1395cc-1 of this title (in this section referred to as the "demonstration program") if such individual—

(A) is enrolled under the program under part B of this subchapter and entitled to benefits under part A of this subchapter; and