Dec. 18, 2015, 129 Stat. 3018; Pub. L. 114–115, § 5, Dec. 28, 2015, 129 Stat. 3133; Pub. L. 114–198, title VII, § 704(h), July 22, 2016, 130 Stat. 752; Pub. L. 114–255, div. A, title V, § 5001, Dec. 13, 2016, 130 Stat. 1188; Pub. L. 115–63, title III, § 303, Sept. 29, 2017, 131 Stat. 1172; Pub. L. 115–123, div. E, title XII, § 53115, Feb. 9, 2018, 132 Stat. 306; Pub. L. 116–260, div. CC, title IV, § 408, Dec. 27, 2020, 134 Stat. 3008.)

AMENDMENTS

2020—Subsec. (b)(1). Pub. L. 116–260 substituted ''$165,000,000'' for ''$0''.

2018—Subsec. (b)(1). Pub. L. 115–123 substituted ''$0'' for ''$220,000,000''.

2017—Subsec. (b)(1). Pub. L. 115–63 substituted ''during and after fiscal year 2021, $220,000,000'' for ''during and after fiscal year 2021, $270,000,000''.

2016—Subsec. (b)(1). Pub. L. 114–255 substituted ''$270,000,000'' for ''$140,000,000''.

Pub. L. 114–198 substituted ''during and after fiscal year 2021, $140,000,000'' for ''during and after fiscal year 2020, $0''.

2015—Subsec. (b)(1). Pub. L. 114–115 substituted ''$0'' for ''$5,000,000''.

Pub. L. 114–113 substituted ''$5,000,000'' for ''$205,000,000''.

Pub. L. 114–60 substituted ''$205,000,000'' for ''$0''.

Pub. L. 114–10 substituted ''$0'' for ''$195,000,000''.

2014—Pub. L. 113–185, § 3(e)(1), substituted ''Medicare Improvement Fund'' for ''Transitional Fund for Sustainable Growth Rate (SGR) Reform'' in section catchline.

Pub. L. 113–82, § 3(1), substituted ''Transitional Fund for Sustainable Growth Rate (SGR) Reform'' for ''Medicare Improvement Fund'' in section catchline.

Subsec. (a). Pub. L. 113–185, § 3(e)(2), amended subsec. (a) generally. Prior to amendment, text read as follows: ''The Secretary shall establish under this subchapter a Transitional Fund for Sustainable Growth Rate (SGR) Reform (in this section referred to as the 'Fund') which shall be available to the Secretary to provide funds to pay for physicians' services under part B to supplement the conversion factor under section 1395w–4(d) of this title for 2017 if the conversion factor for 2017 is less than conversion factor for 2013.''

Pub. L. 113–82, § 3(2), amended subsec. (a) generally. Prior to amendment, text read as follows: ''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.''

Subsec. (b)(1). Pub. L. 113–185, § 3(e)(3), substituted ''during and after fiscal year 2020, $195,000,000.'' for ''during or after 2017, $0.''

Pub. L. 113–93 substituted ''$0'' for ''$2,300,000,000''.

Pub. L. 113–82, § 3(3), substituted ''during or after 2017, $2,300,000,000.'' for ''during—

''(A) fiscal year 2014, $0; and

''(B) fiscal year 2015, $0.''

Subsec. (b)(2). Pub. L. 113–185, § 3(e)(4), substituted ''from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.'' for ''from the Federal Supplementary Medical Insurance Trust Fund.''

Pub. L. 113–82, § 3(4), substituted ''from the Federal Supplementary Medical Insurance Trust Fund.'' for ''from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.''

2013—Subsec. (b)(1). Pub. L. 112–240 added subpars. (A) and (B) and struck out former subpars. (A) to (C) which read as follows:

''(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.''

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.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–198 applicable to prescription drug plans (and MA–PD plans) for plan years beginning on or after Jan. 1, 2019, see section 704(g)(1) of Pub. L. 114–198, set out as a note under section 1395w–101 of this title.

§ 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 co-

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

ordinate 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.

(I) An ACO that seeks to operate an ACO Beneficiary Incentive Program pursuant to subsection (m) shall apply to the Secretary at such time, in such manner, and with such information as the Secretary may require.

(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 requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1395w–4 of this title, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1395w–4 of this title, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

(4) No duplication in participation in shared savings programs

A provider of services or supplier that participates in any of the following shall not be

eligible to participate in an ACO under this section:

(A) A model tested or expanded under section 1315a of this title that involves shared savings under this subchapter, or any other program or demonstration project that involves such shared savings.

(B) The independence at home medical practice pilot program under section 1395cc–5 of this title.

(c) Assignment of Medicare fee-for-service beneficiaries to ACOs

(1) In general

Subject to paragraph (2), the Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of—

(A) in the case of performance years beginning on or after April 1, 2012, primary care services provided under this subchapter by an ACO professional described in subsection (h)(1)(A); and

(B) in the case of performance years beginning on or after January 1, 2019, services provided under this subchapter by a Federally qualified health center or rural health clinic (as those terms are defined in section 1395x(aa) of this title), as may be determined by the Secretary.

(2) Providing flexibility

(A) Choice of prospective assignment

For each agreement period (effective for agreements entered into or renewed on or after January 1, 2020), in the case where an ACO established under the program is in a Track that provides for the retrospective assignment of Medicare fee-for-service beneficiaries to the ACO, the Secretary shall permit the ACO to choose to have Medicare fee-for-service beneficiaries assigned prospectively, rather than retrospectively, to the ACO for an agreement period.

(B) Assignment based on voluntary identification by medicare fee-for-service beneficiaries

(i) In general

For performance year 2018 and each subsequent performance year, if a system is available for electronic designation, the Secretary shall permit a Medicare fee-for-service beneficiary to voluntarily identify an ACO professional as the primary care provider of the beneficiary for purposes of assigning such beneficiary to an ACO, as determined by the Secretary.

(ii) Notification process

The Secretary shall establish a process under which a Medicare fee-for-service beneficiary is—

(I) notified of their ability to make an identification described in clause (i); and

(II) informed of the process by which they may make and change such identification.

(iii) Superseding claims-based assignment

A voluntary identification by a Medicare fee-for-service beneficiary under this subparagraph shall supersede any claims-based assignment otherwise determined by the Secretary.

(d) Payments and treatment of savings

(1) Payments

(A) In general

Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

(ii) the ACO meets the requirement under subparagraph (B)(i).

(B) Savings requirement and benchmark

(i) Determining savings

In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this subchapter, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

(ii) Establish and update benchmark

The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

(2) Payments for shared savings

Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such dif-

ference shall be retained by the program under this subchapter. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

(3) Monitoring avoidance of at-risk patients

If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

(4) Termination

The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

(e) Administration

Chapter 35 of title 44 shall not apply to the program, including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m).

(f) Waiver authority

The Secretary may waive such requirements of sections 1320a–7a and 1320a–7b of this title and this subchapter as may be necessary to carry out the provisions of this section.

(g) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of—

(1) the specification of criteria under subsection (a)(1)(B);

(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

(6) the termination of an ACO under subsection (d)(4) or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m).

(h) Definitions

In this section:

(1) ACO professional

The term ''ACO professional'' means—

(A) a physician (as defined in section 1395x(r)(1) of this title); and

(B) a practitioner described in section 1395u(b)(18)(C)(i) of this title.

(2) Hospital

The term ''hospital'' means a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title).

(3) Medicare fee-for-service beneficiary

The term ''Medicare fee-for-service beneficiary'' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1395mm of this title, or a PACE program under section 1395eee of this title.

(i) Option to use other payment models

(1) In general

If the Secretary determines appropriate, the Secretary may use any of the payment models described in paragraph (2) or (3) for making payments under the program rather than the payment model described in subsection (d).

(2) Partial capitation model

(A) In general

Subject to subparagraph (B), a model described in this paragraph is a partial capitation model in which an ACO is at financial risk for some, but not all, of the items and services covered under parts A and B, such as at risk for some or all physicians' services or all items and services under part B. The Secretary may limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk, as determined to be appropriate by the Secretary.

(B) No additional program expenditures

Payments to an ACO for items and services under this subchapter for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

(3) Other payment models

(A) In general

Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this subchapter.

(B) No additional program expenditures

Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

(j) Involvement in private payer and other third party arrangements

The Secretary may give preference to ACOs who are participating in similar arrangements with other payers.

(k) Treatment of physician group practice demonstration

During the period beginning on March 23, 2010, and ending on the date the program is established, the Secretary may enter into an agreement with an ACO under the demonstration

under section 1395cc–1 of this title, subject to rebasing and other modifications deemed appropriate by the Secretary.

(*l*) Providing ACOs the ability to expand the use of telehealth services

(1) In general

In the case of telehealth services for which payment would otherwise be made under this subchapter furnished on or after January 1, 2020, for purposes of this subsection only, the following shall apply with respect to such services furnished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

(A) Inclusion of home as originating site

Subject to paragraph (3), the home of a beneficiary shall be treated as an originating site described in section 1395m(m)(4)(C)(ii) of this title.

(B) No application of geographic limitation

The geographic limitation under section 1395m(m)(4)(C)(i) of this title shall not apply with respect to an originating site described in section 1395m(m)(4)(C)(ii) of this title (including the home of a beneficiary under subparagraph (A)), subject to State licensing requirements.

(2) Definitions

In this subsection:

(A) Applicable ACO

The term ''applicable ACO'' means an ACO participating in a model tested or expanded under section 1315a of this title or under this section—

(i) that operates under a two-sided model—

(I) described in section 425.600(a) of title 42, Code of Federal Regulations; or

(II) tested or expanded under section 1315a of this title; and

(ii) for which Medicare fee-for-service beneficiaries are assigned to the ACO using a prospective assignment method, as determined appropriate by the Secretary.

(B) Home

The term ''home'' means, with respect to a Medicare fee-for-service beneficiary, the place of residence used as the home of the beneficiary.

(3) Telehealth services received in the home

In the case of telehealth services described in paragraph (1) where the home of a Medicare fee-for-service beneficiary is the originating site, the following shall apply:

(A) No facility fee

There shall be no facility fee paid to the originating site under section 1395m(m)(2)(B) of this title.

(B) Exclusion of certain services

No payment may be made for such services that are inappropriate to furnish in the home setting such as services that are typically furnished in inpatient settings such as a hospital.

(m) Authority to provide incentive payments to beneficiaries with respect to qualifying primary care services

(1) Program

(A) In general

In order to encourage Medicare fee-for-service beneficiaries to obtain medically necessary primary care services, an ACO participating under this section under a payment model described in clause (i) or (ii) of paragraph (2)(B) may apply to establish an ACO Beneficiary Incentive Program to provide incentive payments to such beneficiaries who are furnished qualifying services in accordance with this subsection. The Secretary shall permit such an ACO to establish such a program at the Secretary's discretion and subject to such requirements, including program integrity requirements, as the Secretary determines necessary.

(B) Implementation

The Secretary shall implement this subsection on a date determined appropriate by the Secretary. Such date shall be no earlier than January 1, 2019, and no later than January 1, 2020.

(2) Conduct of program

(A) Duration

Subject to subparagraph (H), an ACO Beneficiary Incentive Program established under this subsection shall be conducted for such period (of not less than 1 year) as the Secretary may approve.

(B) Scope

An ACO Beneficiary Incentive Program established under this subsection shall provide incentive payments to all of the following Medicare fee-for-service beneficiaries who are furnished qualifying services by the ACO:

(i) With respect to the Track 2 and Track 3 payment models described in section 425.600(a) of title 42, Code of Federal Regulations (or in any successor regulation), Medicare fee-for-service beneficiaries who are preliminarily prospectively or prospectively assigned (or otherwise assigned, as determined by the Secretary) to the ACO.

(ii) With respect to any future payment models involving two-sided risk, Medicare fee-for-service beneficiaries who are assigned to the ACO, as determined by the Secretary.

(C) Qualifying service

For purposes of this subsection, a qualifying service is a primary care service, as defined in section 425.20 of title 42, Code of Federal Regulations (or in any successor regulation), with respect to which coinsurance applies under part B, furnished through an ACO by—

(i) an ACO professional described in subsection (h)(1)(A) who has a primary care specialty designation included in the definition of primary care physician under

section 425.20 of title 42, Code of Federal Regulations (or any successor regulation);

(ii) an ACO professional described in subsection (h)(1)(B); or

(iii) a Federally qualified health center or rural health clinic (as such terms are defined in section 1395x(aa) of this title).

(D) Incentive payments

An incentive payment made by an ACO pursuant to an ACO Beneficiary Incentive Program established under this subsection shall be—

(i) in an amount up to $20, with such maximum amount updated annually by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ii) in the same amount for each Medicare fee-for-service beneficiary described in clause (i) or (ii) of subparagraph (B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1395ss(g)(1) of this title), in a State Medicaid plan under subchapter XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

(iii) made for each qualifying service furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B) during a period specified by the Secretary; and

(iv) made no later than 30 days after a qualifying service is furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B).

(E) No separate payments from the Secretary

The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this subparagraph shall be construed as prohibiting an ACO from using shared savings received under this section to carry out an ACO Beneficiary Incentive Program.

(F) No application to shared savings calculation

Incentive payments made by an ACO under this subsection shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings under this section.

(G) Reporting requirements

An ACO conducting an ACO Beneficiary Incentive Program under this subsection shall, at such times and in such format as the Secretary may require, report to the Secretary such information and retain such documentation as the Secretary may require, including the amount and frequency of incentive payments made and the number of Medicare fee-for-service beneficiaries receiving such payments.

(H) Termination

The Secretary may terminate an ACO Beneficiary Incentive Program established under this subsection at any time for reasons determined appropriate by the Secretary.

(3) Exclusion of incentive payments

Any payment made under an ACO Beneficiary Incentive Program established under this subsection shall not be considered income or resources or otherwise taken into account for purposes of—

(A) determining eligibility for benefits or assistance (or the amount or extent of benefits or assistance) under any Federal program or under any State or local program financed in whole or in part with Federal funds; or

(B) any Federal or State laws relating to taxation.

(Aug. 14, 1935, ch. 531, title XVIII, §1899, as added and amended Pub. L. 111–148, title III, §3022, title X, §10307, Mar. 23, 2010, 124 Stat. 395, 940; Pub. L. 114–255, div. C, title XVII, §17007, Dec. 13, 2016, 130 Stat. 1338; Pub. L. 115–123, div. E, title III, §§50324(a), 50331, 50341(a), Feb. 9, 2018, 132 Stat. 203, 205, 206.)

AMENDMENTS

2018—Subsec. (b)(2)(I). Pub. L. 115–123, §50341(a)(1), added subpar. (I).

Subsec. (c). Pub. L. 115–123, §50331, designated existing provisions as par. (1), inserted heading, substituted ''Subject to paragraph (2), the Secretary'' for ''The Secretary'', redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, and added par. (2).

Subsec. (e). Pub. L. 115–123, §50341(a)(3), inserted '', including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)'' after ''the program''.

Subsec. (g)(6). Pub. L. 115–123, §50341(a)(4), inserted ''or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)'' after ''under subsection (d)(4)''.

Subsec. (*l*). Pub. L. 115–123, §50324(a), added subsec. (*l*).

Subsec. (m). Pub. L. 115–123, §50341(a)(2), added subsec. (m).

2016—Subsec. (c). Pub. L. 114–255 substituted ''utilization of—'' for ''utilization of primary'', inserted par. (1) designation and ''in the case of performance years beginning on or after April 1, 2012, primary'' before ''care services'', and added par. (2).

2010—Subsecs. (i) to (k). Pub. L. 111–148, §10307, added subsecs. (i) to (k).

STUDY AND REPORT

Pub. L. 115–123, div. E, title III, §50324(b), Feb. 9, 2018, 132 Stat. 204, provided that:

''(1) STUDY.—

''(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct a study on the implementation of section 1899(*l*) of the Social Security Act [42 U.S.C. 1395jjj(*l*)], as added by subsection (a). Such study shall include an analysis of the utilization of, and expenditures for, telehealth services under such section.

''(B) COLLECTION OF DATA.—The Secretary may collect such data as the Secretary determines necessary to carry out the study under this paragraph.

''(2) REPORT.—Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''

§ 1395kkk. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(a), Feb. 9, 2018, 132 Stat. 298

Section, Aug. 14, 1935, ch. 531, title XVIII, § 1899A, as added and amended Pub. L. 111–148, title III, § 3403(a)(1), title X, § 10320(a), Mar. 23, 2010, 124 Stat. 489, 949, established the Independent Payment Advisory Board.

CHANGE OF NAME

Pub. L. 111–148, title X, § 10320(b), Mar. 23, 2010, 124 Stat. 952, which provided that any reference in the provisions of, or amendments made by, section 3403 of Pub. L. 111–148 (enacting this section and section 1395kkk–1 of this title and amending section 1395b–6 of this title and section 207 of Title 18, Crimes and Criminal Procedure) to the ''Independent Medicare Advisory Board'' be deemed to be a reference to the ''Independent Payment Advisory Board'', was repealed by Pub. L. 115–123, div. E, title XI, § 52001(b)(4), Feb. 9, 2018, 132 Stat. 298.

CONSTRUCTION

Pub. L. 111–148, title X, § 10320(c), Mar. 23, 2010, 124 Stat. 952, which provided that nothing in the amendments made by section 10320 of Pub. L. 111–148 precluded the Independent Medicare Advisory Board (renamed the Independent Payment Advisory Board) from solely using data from public or private sources to carry out former subsection (f)(3)(B) of this section, was repealed by Pub. L. 115–123, div. E, title XI, § 52001(b)(5), Feb. 9, 2018, 132 Stat. 298.

§ 1395kkk–1. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(b)(2), Feb. 9, 2018, 132 Stat. 298

Section, Pub. L. 111–148, title III, § 3403(b), Mar. 23, 2010, 124 Stat. 506, related to GAO study and report on determination and implementation of payment and coverage policies under the Medicare program.

§ 1395*lll*. Standardized post-acute care (PAC) assessment data for quality, payment, and discharge planning

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

(i) standardized patient assessment data in accordance with subsection (b);

(ii) data on quality measures under subsection (c)(1); and

(iii) data on resource use and other measures under subsection (d)(1);

(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

(i) provide for the submission of standardized patient assessment data under this subchapter with respect to such providers; and

(ii) enable comparison of such assessment data across all such providers to whom such data are applicable.

(2) Definitions

For purposes of this section:

(A) Post-acute care (PAC) provider

The terms ''post-acute care provider'' and ''PAC provider'' mean—

(i) a home health agency;

(ii) a skilled nursing facility;

(iii) an inpatient rehabilitation facility; and

(iv) a long-term care hospital (other than a hospital classified under section 1395ww(d)(1)(B)(vi) of this title).

(B) PAC assessment instrument

The term ''PAC assessment instrument'' means—

(i) in the case of home health agencies, the instrument used for purposes of reporting and assessment with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;

(ii) in the case of skilled nursing facilities, the resident's assessment under section 1395i–3(b)(3) of this title;

(iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1395ww(j) of this title; and

(iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754–51755), including for purposes of section 1395ww(m)(5)(C) of this title, or any other instrument used with respect to such hospitals for assessment purposes.

(C) Applicable reporting provision

The term ''applicable reporting provision'' means—

(i) for home health agencies, section 1395fff(b)(3)(B)(v) of this title;

(ii) for skilled nursing facilities, section 1395yy(e)(6) of this title;

(iii) for inpatient rehabilitation facilities, section 1395ww(j)(7) of this title; and

(iv) for long-term care hospitals, section 1395ww(m)(5) of this title.

(D) PAC payment system

The term ''PAC payment system'' means—

(i) with respect to a home health agency, the prospective payment system under section 1395fff of this title;

(ii) with respect to a skilled nursing facility, the prospective payment system under section 1395yy(e) of this title;

(iii) with respect to an inpatient rehabilitation facility, the prospective pay-