(3) Collection

Such coinsurance and deductible shall be collected by the contractor that supplies the drug or biological involved. Subject to subsection (a)(3)(B), such coinsurance and deductible may be collected in a manner similar to the manner in which the coinsurance and deductible are collected for durable medical equipment under this part.

(f) Special payment rules

(1) Use in exclusion cases

If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for payment to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1395w–3a of this title.

(2) Application of requirement for assignment

For provision requiring assignment of claims for competitively biddable drugs and biologicals, see section 1395u(*o*)(3) of this title.

(3) Protection for beneficiary in case of medical necessity denial

For protection of individuals against liability in the case of medical necessity determinations, see section 1395u(b)(3)(B)(ii)(III) of this title.

(g) Judicial 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 establishment of payment amounts under subsection (d)(1);

(2) the awarding of contracts under this section;

(3) the establishment of competitive acquisition areas under subsection (a)(2)(C);

(4) the phased-in implementation under subsection (a)(1)(B);

(5) the selection of categories of competitively biddable drugs and biologicals for competitive acquisition under such subsection or the selection of a drug in the case of multiple source drugs; or

(6) the bidding structure and number of contractors selected under this section.

(Aug. 14, 1935, ch. 531, title XVIII, §1847B, as added Pub. L. 108–173, title III, §303(d)(1), Dec. 8, 2003, 117 Stat. 2245; amended Pub. L. 109–432, div. B, title I, §108(a), Dec. 20, 2006, 120 Stat. 2983.)

Editorial Notes

REFERENCES IN TEXT

Section 1395ee(b) of this title, referred to in subsec. (b)(2)(C), was added by section 942(a)(5) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, not section 923 of that Act, and relates to the Council for Technology and Innovation, not to the Medicare Provider Ombudsman.

The Federal Food, Drug, and Cosmetic Act, referred to in subsec. subsec. (b)(4)(C), is act June 25, 1938, ch. 675, 52 Stat. 1040, as amended, which is classified generally to chapter 9 (§301 et seq.) of Title 21, Food and Drugs. For complete classification of this Act to the Code, see section 301 of Title 21 and Tables.

AMENDMENTS

2006—Subsec. (a)(3)(A)(iii). Pub. L. 109–432, §108(a)(1), substituted ''and biologicals shall be made only to such contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary.'' for ''and biologicals—

''(I) shall be made only to such contractor; and

''(II) shall be conditioned upon the administration of such drugs and biologicals.''

Subsec. (a)(3)(D). Pub. L. 109–432, §108(a)(2), added subpar. (D).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §108(c), Dec. 20, 2006, 120 Stat. 2983, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to payment for drugs and biologicals supplied under section 1847B of the Social Security Act (42 U.S.C. 1395w–3b)—

''(1) on or after April 1, 2007; and

''(2) on or after July 1, 2006, and before April 1, 2007, for claims that are unpaid as of April 1, 2007.''

CONSTRUCTION OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title I, §108(b), Dec. 20, 2006, 120 Stat. 2983, provided that: ''Nothing in this section [amending this section and enacting provisions set out as a note above] shall be construed as—

''(1) requiring the conduct of any additional competition under subsection (b)(1) of section 1847B of the Social Security Act (42 U.S.C. 1395w–3b); or

''(2) requiring any additional process for elections by physicians under subsection (a)(1)(A)(ii) of such section or additional selection by a selecting physician of a contractor under subsection (a)(5) of such section.''

REPORT

Pub. L. 108–173, title III, §303(d)(2), Dec. 8, 2003, 117 Stat. 2252, provided that: ''Not later than July 1, 2008, the Secretary [of Health and Human Services] shall submit to Congress a report on the program conducted under section 1847B of the Social Security Act [42 U.S.C. 1395w–3b], as added by paragraph (1). Such report shall include information on savings, reductions in cost-sharing, access to competitively biddable drugs and biologicals, the range of choices of contractors available to physicians, the satisfaction of physicians and of individuals enrolled under this part [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.], and information comparing prices for drugs and biologicals under such section and section 1847A of such Act [42 U.S.C. 1395w–3a], as added by subsection (c).''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

§ 1395w–4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this

part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part shall instead be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) for services furnished during that year (in this subsection referred to as the ''fee schedule amount'').

(2) Transition to full fee schedule

(A) Limiting reductions and increases to 15 percent in 1992

(i) Limit on increase

In the case of a service in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) Limit in reduction

In the case of a service in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(B) Special rule for 1993, 1994, and 1995

If a physicians' service in a fee schedule area is subject to the provisions of subparagraph (A) in 1992, for physicians' services furnished in the area—

(i) during 1993, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 75 percent of the fee schedule amount determined under subparagraph (A), adjusted by the update established under subsection (d)(3) for 1993, and

(II) 25 percent of the fee schedule amount determined under paragraph (1) for 1993 without regard to this paragraph;

(ii) during 1994, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 67 percent of the fee schedule amount determined under clause (i), adjusted by the update established under subsection (d)(3) for 1994 and as adjusted under subsection (c)(2)(F)(ii) and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, and

(II) 33 percent of the fee schedule amount determined under paragraph (1) for 1994 without regard to this paragraph; and

(iii) during 1995, there shall be substituted for the fee schedule amount an amount equal to the sum of—

(I) 50 percent of the fee schedule amount determined under clause (ii) adjusted by the update established under subsection (d)(3) for 1995, and

(II) 50 percent of the fee schedule amount determined under paragraph (1) for 1995 without regard to this paragraph.

(C) Special rule for anesthesia and radiology services

With respect to physicians' services which are anesthesia services, the Secretary shall provide for a transition in the same manner as a transition is provided for other services under subparagraph (B). With respect to radiology services, ''109 percent'' and ''9 percent'' shall be substituted for ''115 percent'' and ''15 percent'', respectively, in subparagraph (A)(ii).

(D) "Adjusted historical payment basis" defined

(i) In general

In this paragraph, the term ''adjusted historical payment basis'' means, with respect to a physicians' service furnished in a fee schedule area, the weighted average prevailing charge applied in the area for the service in 1991 (as determined by the Secretary without regard to physician specialty and as adjusted to reflect payments for services with customary charges below the prevailing charge or other payment limitations imposed by law or regulation) adjusted by the update established under subsection (d)(3) for 1992.

(ii) Application to radiology services

In applying clause (i) in the case of physicians' services which are radiology services (including radiologist services, as defined in section 1395m(b)(6) of this title), but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under the fee schedule established for the service for the fee schedule area under section 1395m(b) of this title.

(iii) Nuclear medicine services

In applying clause (i) in the case of physicians' services which are nuclear medicine services, there shall be substituted for the weighted average prevailing charge the amount provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) Incentives for participating physicians and suppliers

In applying paragraph (1)(B) in the case of a nonparticipating physician or a nonparticipating supplier or other person, the fee sched-

ule amount shall be 95 percent of such amount otherwise applied under this subsection (without regard to this paragraph). In the case of physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.

(4) Special rule for medical direction

(A) In general

With respect to physicians' services furnished on or after January 1, 1994, and consisting of medical direction of two, three, or four concurrent anesthesia cases, except as provided in paragraph (5), the fee schedule amount to be applied shall be equal to one-half of the amount described in subparagraph (B).

(B) Amount

The amount described in this subparagraph, for a physician's medical direction of the performance of anesthesia services, is the following percentage of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the physician alone:

(i) For services furnished during 1994, 120 percent.

(ii) For services furnished during 1995, 115 percent.

(iii) For services furnished during 1996, 110 percent.

(iv) For services furnished during 1997, 105 percent.

(v) For services furnished after 1997, 100 percent.

(5) Incentives for electronic prescribing

(A) Adjustment

(i) In general

Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2012, 2013 or 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) Applicable percent

For purposes of clause (i), the term ''applicable percent'' means—

(I) for 2012, 99 percent;

(II) for 2013, 98.5 percent; and

(III) for 2014, 98 percent.

(B) Significant hardship exception

The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access.

(C) Application

(i) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) Incentive payment validation rules

Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(D) Definitions

For purposes of this paragraph:

(i) Eligible professional; covered professional services

The terms ''eligible professional'' and ''covered professional services'' have the meanings given such terms in subsection (k)(3).

(ii) Physician reporting system

The term ''physician reporting system'' means the system established under subsection (k).

(iii) Reporting period

The term ''reporting period'' means, with respect to a year, a period specified by the Secretary.

(6) Special rule for teaching anesthesiologists

With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

(A) the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and

(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(7) Incentives for meaningful use of certified EHR technology

(A) Adjustment

(i) In general

Subject to subparagraphs (B) and (D), with respect to covered professional serv-

ices furnished by an eligible professional during each of 2015 through 2018, if the eligible professional is not a meaningful EHR user (as determined under subsection (*o*)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) Applicable percent

Subject to clause (iii), for purposes of clause (i), the term ''applicable percent'' means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under subsection (a)(5) for 2014, 98 percent);

(II) for 2016, 98 percent; and

(III) for 2017 and 2018, 97 percent.

(iii) Authority to decrease applicable percentage for 2018

For 2018, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (*o*)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year.

(B) Significant hardship exception

The Secretary may, on a case-by-case basis (and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016), exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

(C) Application of physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(D) Non-application to hospital-based and ambulatory surgical center-based eligible professionals

(i) Hospital-based

No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (*o*)(1)(C)(ii)).

(ii) Ambulatory surgical center-based

Subject to clause (iv), no payment adjustment may be made under subparagraph (A) for 2017 and 2018 in the case of an eligible professional with respect to whom substantially all of the covered professional services furnished by such professional are furnished in an ambulatory surgical center.

(iii) Determination

The determination of whether an eligible professional is an eligible professional described in clause (ii) may be made on the basis of—

(I) the site of service (as defined by the Secretary); or

(II) an attestation submitted by the eligible professional.

Determinations made under subclauses (I) and (II) shall be made without regard to any employment or billing arrangement between the eligible professional and any other supplier or provider of services.

(iv) Sunset

Clause (ii) shall no longer apply as of the first year that begins more than 3 years after the date on which the Secretary determines, through notice and comment rulemaking, that certified EHR technology applicable to the ambulatory surgical center setting is available.

(E) Definitions

For purposes of this paragraph:

(i) Covered professional services

The term ''covered professional services'' has the meaning given such term in subsection (k)(3).

(ii) EHR reporting period

The term ''EHR reporting period'' means, with respect to a year, a period (or periods) specified by the Secretary.

(iii) Eligible professional

The term ''eligible professional'' means a physician, as defined in section 1395x(r) of this title.

(8) Incentives for quality reporting

(A) Adjustment

(i) In general

With respect to covered professional services furnished by an eligible profes-

sional during each of 2015 through 2018, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

(ii) Applicable percent

For purposes of clause (i), the term ''applicable percent'' means—

(I) for 2015, 98.5 percent; and

(II) for 2016, 2017, and 2018, 98 percent.

(B) Application

(i) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

(ii) Incentive payment validation rules

Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(C) Definitions

For purposes of this paragraph:

(i) Eligible professional; covered professional services

The terms ''eligible professional'' and ''covered professional services'' have the meanings given such terms in subsection (k)(3).

(ii) Physician reporting system

The term ''physician reporting system'' means the system established under subsection (k).

(iii) Quality reporting period

The term ''quality reporting period'' means, with respect to a year, a period specified by the Secretary.

(9) Information reporting on services included in global surgical packages

With respect to services for which a physician is required to report information in accordance with subsection (c)(8)(B)(i), the Secretary may through rulemaking delay payment of 5 percent of the amount that would otherwise be payable under the physician fee schedule under this section for such services until the information so required is reported.

(b) Establishment of fee schedules

(1) In general

Before November 1 of the preceding year, for each year beginning with 1998, subject to subsection (p), the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas (as defined in subsection (j)(2)) for the year. Except as provided in paragraph (2), each such payment amount for a service shall be equal to the product of—

(A) the relative value for the service (as determined in subsection (c)(2)),

(B) the conversion factor (established under subsection (d)) for the year, and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area.

(2) Treatment of radiology services and anesthesia services

(A) Radiology services

With respect to radiology services (including radiologist services, as defined in section 1395m(b)(6) of this title), the Secretary shall base the relative values on the relative value scale developed under section 1395m(b)(1)(A) of this title, with appropriate modifications of the relative values to assure that the relative values established for radiology services which are similar or related to other physicians' services are consistent with the relative values established for those similar or related services.

(B) Anesthesia services

In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

(C) Consultation

The Secretary shall consult with the Physician Payment Review Commission and organizations representing physicians or suppliers who furnish radiology services and anesthesia services in applying subparagraphs (A) and (B).

(3) Treatment of interpretation of electrocardiograms

The Secretary—

(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations.

(4) Special rule for imaging services

(A) In general

In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

(i) the technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule described in paragraph (1) without application of the geographic adjustment factor described in paragraph (1)(C), exceeds

(ii) the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1395*l*(t) of this title for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), for the fee schedule amount for such technical component for such year.

(B) Imaging services described

For purposes of subparagraph (A), imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, and for 2010, 2011, and the first 2 months of 2012, dual-energy x-ray absorptiometry services (as described in paragraph (6)).

(C) Adjustment in imaging utilization rate

With respect to fee schedules established for 2011, 2012, and 2013, in the methodology for determining practice expense relative value units for expensive diagnostic imaging equipment under the final rule published by the Secretary in the Federal Register on November 25, 2009 (42 CFR 410 et al.), the Secretary shall use a 75 percent assumption instead of the utilization rates otherwise established in such final rule. With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.

(D) Adjustment in technical component discount on single-session imaging involving consecutive body parts

For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.

(5) Treatment of intensive cardiac rehabilitation program

(A) In general

In the case of an intensive cardiac rehabilitation program described in section 1395x(eee)(4) of this title, the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service under paragraph (3)(D) of section 1395*l*(t) of this title for cardiac rehabilitation (under HCPCS codes 93797 and 93798 for calendar year 2007, or any succeeding HCPCS codes for cardiac rehabilitation).

(B) Definition of session

Each of the services described in subparagraphs (A) through (E) of section 1395x(eee)(3) of this title, when furnished for one hour, is a separate session of intensive cardiac rehabilitation.

(C) Multiple sessions per day

Payment may be made for up to 6 sessions per day of the series of 72 one-hour sessions of intensive cardiac rehabilitation services described in section 1395x(eee)(4)(B) of this title.

(6) Treatment of bone mass scans

For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010, 2011, and the first 2 months of 2012, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

(B) the conversion factor (established under subsection (d)) for 2006; and

(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010, 2011, and the first 2 months of 2012, respectively.

(7) Adjustment in discount for certain multiple therapy services

In the case of therapy services furnished on or after January 1, 2011, and before April 1, 2013, and for which payment is made under fee schedules established under this section, instead of the 25 percent multiple procedure payment reduction specified in the final rule published by the Secretary in the Federal Register on November 29, 2010, the reduction percentage shall be 20 percent. In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.

(8) Encouraging care management for individuals with chronic care needs

(A) In general

In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a phy-

sician (as defined in section 1395x(r)(1) of this title), physician assistant or nurse practitioner (as defined in section 1395x(aa)(5)(A) of this title), clinical nurse specialist (as defined in section 1395x(aa)(5)(B) of this title), or certified nurse midwife (as defined in section 1395x(gg)(2) of this title).

(B) Policies relating to payment

In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

(i) make payment to only one applicable provider for such services furnished to an individual during a period;

(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this subchapter for such services; and

(iii) not require that an annual wellness visit (as defined in section 1395x(hhh) of this title) or an initial preventive physical examination (as defined in section 1395x(ww) of this title) be furnished as a condition of payment for such management services.

(9) Special rule to incentivize transition from traditional X-ray imaging to digital radiography

(A) Limitation on payment for film X-ray imaging services

In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 20 percent.

(B) Phased-in limitation on payment for computed radiography imaging services

In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using computed radiography technology—

(i) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 7 percent; and

(ii) in the case of such a service furnished during 2023 or a subsequent year, the payment amount for the technical component (including the technical component portion of a global service) of such service that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this section) for such year shall be reduced by 10 percent.

(C) Computed radiography technology defined

For purposes of this paragraph, the term ''computed radiography technology'' means cassette-based imaging which utilizes an imaging plate to create the image involved.

(D) Implementation

In order to implement this paragraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(10) Reduction of discount in payment for professional component of multiple imaging services

In the case of the professional component of imaging services furnished on or after January 1, 2017, instead of the 25 percent reduction for multiple procedures specified in the final rule published by the Secretary in the Federal Register on November 28, 2011, as amended in the final rule published by the Secretary in the Federal Register on November 16, 2012, the reduction percentage shall be 5 percent.

(11) Special rule for certain radiation therapy services

The code definitions, the work relative value units under subsection (c)(2)(C)(i), and the direct inputs for the practice expense relative value units under subsection (c)(2)(C)(ii) for radiation treatment delivery and related imaging services (identified in 2016 by HCPCS G-codes G6001 through G6015) for the fee schedule established under this subsection for services furnished in 2017, 2018, and 2019 shall be the same as such definitions, units, and inputs for such services for the fee schedule established for services furnished in 2016.

(c) Determination of relative values for physicians' services

(1) Division of physicians' services into components

In this section, with respect to a physicians' service:

(A) "Work component" defined

The term ''work component'' means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—

(i) include activities before and after direct patient contact, and

(ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services.

(B) "Practice expense component" defined

The term ''practice expense component'' means the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

(C) "Malpractice component" defined

The term ''malpractice component'' means the portion of the resources used in fur-

nishing the service that reflects malpractice expenses in furnishing the service.

(2) Determination of relative values

(A) In general

(i) Combination of units for components

The Secretary shall develop a methodology for combining the work, practice expense, and malpractice relative value units, determined under subparagraph (C), for each service in a manner to produce a single relative value for that service. Such relative values are subject to adjustment under subparagraph (F)(i) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993.

(ii) Extrapolation

The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the Physician Payment Review Commission and the results of consultations with organizations representing physicians who provide such services.

(B) Periodic review and adjustments in relative values

(i) Periodic review

The Secretary, not less often than every 5 years, shall review the relative values established under this paragraph for all physicians' services.

(ii) Adjustments

(I) In general

The Secretary shall, to the extent the Secretary determines to be necessary and subject to subclause (II) and paragraph (7), adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

(II) Limitation on annual adjustments

Subject to clauses (iv) and (v), the adjustments under subclause (I) for a year may not cause the amount of expenditures under this part for the year to differ by more than $20,000,000 from the amount of expenditures under this part that would have been made if such adjustments had not been made.

(iii) Consultation

The Secretary, in making adjustments under clause (ii), shall consult with the Medicare Payment Advisory Commission and organizations representing physicians.

(iv) Exemption of certain additional expenditures from budget neutrality

The additional expenditures attributable to—

(I) subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004;

(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II);

(III) subparagraph (J) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year;

(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010, 2011, or the first 2 months of 2012; and

(V) subsection (t) shall not be taken into account in applying clause (ii)(II) for 2021 or 2022.

(v) Exemption of certain reduced expenditures from budget-neutrality calculation

The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) Reduced payment for multiple imaging procedures

Effective for fee schedules established beginning with 2007, reduced expenditures attributable to the multiple procedure payment reduction for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) insofar as it relates to the physician fee schedules for 2006 and 2007.

(II) OPD payment cap for imaging services

Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

(III) Change in utilization rate for certain imaging services

Effective for fee schedules established beginning with 2011, reduced expenditures attributable to the changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of subsection (b)(4)(C).

(IV), (V) Repealed. Pub. L. 111–152, title I, § 1107(2), Mar. 30, 2010, 124 Stat. 1050

(VI) Additional reduced payment for multiple imaging procedures

Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).

(VII) Reduced expenditures for multiple therapy services

Effective for fee schedules established beginning with 2011, reduced expendi-

tures attributable to the multiple procedure payment reduction for therapy services (as described in subsection (b)(7)).

(VIII) Reduced expenditures attributable to application of quality incentives for computed tomography

Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1395m(p) of this title[1]

(IX) Reductions for misvalued services if target not met

Effective for fee schedules beginning with 2016, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).

(X) Reduced expenditures attributable to incentives to transition to digital radiography

Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subparagraph (A) of subsection (b)(9) and effective for fee schedules established beginning with 2018, reduced expenditures attributable to subparagraph (B) of such subsection.

(XI) Discount in payment for professional component of imaging services

Effective for fee schedules established beginning with 2017, reduced expenditures attributable to subsection (b)(10).

(vi) Alternative application of budget-neutrality adjustment

Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for years beginning with 2009.

(C) Computation of relative value units for components

For purposes of this section for each physicians' service—

(i) Work relative value units

The Secretary shall determine a number of work relative value units for the service or group of services based on the relative resources incorporating physician time and intensity required in furnishing the service or group of services.

(ii) Practice expense relative value units

The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)),

and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service or group of services. For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.

(iii) Malpractice relative value units

The Secretary shall determine a number of malpractice relative value units for the service or group of services for years before 2000 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service or group of services, and

(II) the malpractice percentage for the service or group of services (as determined under paragraph (3)(C)(iii)),

and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service or group of services.

(D) "Base allowed charges" defined

In this paragraph, the term ''base allowed charges'' means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available.

(E) Reduction in practice expense relative value units for certain services

(i) In general

Subject to clause (ii), the Secretary shall reduce the practice expense relative value units applied to services described in clause (iii) furnished in—

(I) 1994, by 25 percent of the number by which the number of practice expense relative value units (determined for 1994 without regard to this subparagraph) exceeds the number of work relative value units determined for 1994,

(II) 1995, by an additional 25 percent of such excess, and

(III) 1996, by an additional 25 percent of such excess.

(ii) Floor on reductions

The practice expense relative value units for a physician's service shall not be re-

[1] So in original. Probably should be followed by a period.

duced under this subparagraph to a number less than 128 percent of the number of work relative value units.

(iii) Services covered

For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iv) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1994) exceeds 128 percent of the number of work relative value units (determined for such year).

(iv) Excluded services

For purposes of clause (iii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this subchapter in an office setting.

(F) Budget neutrality adjustments

The Secretary—

(i) shall reduce the relative values for all services (other than anesthesia services) established under this paragraph (and, in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made, and

(ii) shall reduce the amounts determined under subsection (a)(2)(B)(ii)(I) by such percentage as the Secretary determines to be required to assure that, taking into account the reductions made under clause (i), the amendment made by section 13514(a) of the Omnibus Budget Reconciliation Act of 1993 would not result in expenditures under this section in 1994 that exceed the amount of such expenditures that would have been made if such amendment had not been made.

(G) Adjustments in relative value units for 1998

(i) In general

The Secretary shall—

(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

(ii) Services covered

For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

(I) there are work relative value units, and

(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

(iii) Excluded services

For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this subchapter in an office setting.

(iv) Limitation on aggregate reallocation

If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

(v) No reduction for certain services

Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).

(H) Adjustments in practice expense relative value units for certain drug administration services beginning in 2004

(i) Use of survey data

In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

(I) covers practice expenses for oncology drug administration services; and

(II) meets criteria established by the Secretary for acceptance of such surveys.

(ii) Pricing of clinical oncology nurses in practice expense methodology

If the survey described in clause (i) includes data on wages, salaries, and compensation of clinical oncology nurses, the Secretary shall utilize such data in the methodology for determining practice expense relative value units under subsection (c).

(iii) Work relative value units for certain drug administration services

In establishing the relative value units under this paragraph for drug administra-

tion services described in clause (iv) furnished on or after January 1, 2004, the Secretary shall establish work relative value units equal to the work relative value units for a level 1 office medical visit for an established patient.

(iv) Drug administration services described

The drug administration services described in this clause are physicians' services—

(I) which are classified as of October 1, 2003, within any of the following groups of procedures: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections;

(II) for which there are no work relative value units assigned under this subsection as of such date; and

(III) for which national relative value units have been assigned under this subsection as of such date.

(I) Adjustments in practice expense relative value units for certain drug administration services beginning with 2005

(i) In general

In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2005 or 2006, the Secretary shall adjust the practice expense relative value units for such year consistent with clause (ii).

(ii) Use of supplemental survey data

(I) In general

Subject to subclause (II), if a specialty submits to the Secretary by not later than March 1, 2004, for 2005, or March 1, 2005, for 2006, data that includes expenses for the administration of drugs and biologicals for which the payment amount is determined pursuant to section 1395u(*o*) of this title, the Secretary shall use such supplemental survey data in carrying out this subparagraph for the years involved insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(II) Limitation on specialty

Subclause (I) shall apply to a specialty only insofar as not less than 40 percent of payments for the specialty under this subchapter in 2002 are attributable to the administration of drugs and biologicals, as determined by the Secretary.

(III) Application

This clause shall not apply with respect to a survey to which subparagraph (H)(i) applies.

(J) Provisions for appropriate reporting and billing for physicians' services associated with the administration of covered outpatient drugs and biologicals

(i) Evaluation of codes

The Secretary shall promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption.

(ii) Use of existing processes

In carrying out clause (i), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

(iii) Implementation

In carrying out clause (i), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1395w–3a of this title or section 1395w–3b of this title, and shall take such steps within the Secretary's authority to expedite such considerations under clause (ii).

(iv) Subsequent, budget neutral adjustments permitted

Nothing in subparagraph (H) or (I) or this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2004, 2005, or 2006, respectively.

(K) Potentially misvalued codes

(i) In general

The Secretary shall—

(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

(ii) Identification of potentially misvalued codes

For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

(I) Codes that have experienced the fastest growth.

(II) Codes that have experienced substantial changes in practice expenses.

(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

(VI) Codes that have not been subject to review since implementation of the fee schedule.

(VII) Codes that account for the majority of spending under the physician fee schedule.

(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

(XI) Codes for which there may be anomalies in relative values within a family of codes.

(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

(XIII) Codes with high intra-service work per unit of time.

(XIV) Codes with high practice expense relative value units.

(XV) Codes with high cost supplies.

(XVI) Codes as determined appropriate by the Secretary.

(iii) Review and adjustments

(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

(VI) The provisions of subparagraph (B)(ii)(II) and paragraph (7) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(I).

(iv) Treatment of certain radiation therapy services

Radiation treatment delivery and related imaging services identified under subsection (b)(11) shall not be considered as potentially misvalued services for purposes of this subparagraph and subparagraph (O) for 2017, 2018, and 2019.

(L) Validating relative value units

(i) In general

The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

(ii) Components and elements of work

The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

(iii) Scope of codes

The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

(iv) Methods

The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) Adjustments

The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(M) Authority to collect and use information on physicians' services in the determination of relative values

(i) Collection of information

Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

(ii) Use of information

Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

(iii) Types of information

The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

(I) Time involved in furnishing services.

(II) Amounts and types of practice expense inputs involved with furnishing services.

(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

(IV) Overhead and accounting information for practices of physicians and other suppliers.

(V) Any other element that would improve the valuation of services under this section.

(iv) Information collection mechanisms

Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

(II) Surgical logs, billing systems, or other practice or facility records.

(III) Electronic health records.

(IV) Any other mechanism determined appropriate by the Secretary.

(v) Transparency of use of information

(I) In general

Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

(II) Thresholds for use

The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

(III) Disclosure of information

The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

(vi) Incentive to participate

The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

(vii) Administration

Chapter 35 of title 44 shall not apply to information collected or obtained under this subparagraph.

(viii) Definition of eligible professional

In this subparagraph, the term ''eligible professional'' has the meaning given such term in subsection (k)(3)(B).

(ix) Funding

For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.

(N) Authority for alternative approaches to establishing practice expense relative values

The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).

(O) Target for relative value adjustments for misvalued services

With respect to fee schedules established for each of 2016 through 2018, the following shall apply:

(i) Determination of net reduction in expenditures

For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

(ii) Budget neutral redistribution of funds if target met and counting overages towards the target for the succeeding year

If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of de-

termining whether the target has or has not been met under this subparagraph with respect to that year.

(iii) Exemption from budget neutrality if target not met

If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2016.

(iv) Target recapture amount

For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

(I) the target for the year; and

(II) the estimated net reduction in expenditures determined under clause (i) for the year.

(v) Target

For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent (or, for 2016, 1.0 percent) of the estimated amount of expenditures under the fee schedule under this section for the year.

(3) Component percentages

For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) Division of services by specialty

For each physician's service or class of physicians' services, the Secretary shall determine the average percentage of each such service or class of services that is performed, nationwide, under this part by physicians in each of the different physician specialties (as identified by the Secretary).

(B) Division of specialty by component

The Secretary shall determine the average percentage division of resources, among the work component, the practice expense component, and the malpractice component, used by physicians in each of such specialties in furnishing physicians' services. Such percentages shall be based on national data that describe the elements of physician practice costs and revenues, by physician specialty. The Secretary may use extrapolation and other techniques to determine practice costs and revenues for specialties for which adequate data are not available.

(C) Determination of component percentages

(i) Work percentage

The work percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the work component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(ii) Practice expense percentage

For years before 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(iii) Malpractice percentage

For years before 1999, the malpractice percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the malpractice component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

(D) Periodic recomputation

The Secretary may, from time to time, provide for the recomputation of work percentages, practice expense percentages, and malpractice percentages determined under this paragraph.

(4) Ancillary policies

The Secretary may establish ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement this section.

(5) Coding

The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

(6) No variation for specialists

The Secretary may not vary the conversion factor or the number of relative value units for a physicians' service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.

(7) Phase-in of significant relative value unit (RVU) reductions

Effective for fee schedules established beginning with 2016, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the

total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.

(8) Global surgical packages

(A) Prohibition of implementation of rule regarding global surgical packages

(i) In general

The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods.

(ii) Construction

Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services.

(B) Collection of data on services included in global surgical packages

(i) In general

Subject to clause (ii), the Secretary shall through rulemaking develop and implement a process to gather, from a representative sample of physicians, beginning not later than January 1, 2017, information needed to value surgical services. Such information shall include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period, as appropriate. Such information shall be reported on claims at the end of the global period or in another manner specified by the Secretary. For purposes of carrying out this paragraph (other than clause (iii)), the Secretary shall transfer from the Federal Supplemental Medical Insurance Trust Fund under section 1395t of this title $2,000,000 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year 2015. Amounts transferred under the previous sentence shall remain available until expended.

(ii) Reassessment and potential sunset

Every 4 years, the Secretary shall reassess the value of the information collected pursuant to clause (i). Based on such a reassessment and by regulation, the Secretary may discontinue the requirement for collection of information under such clause if the Secretary determines that the Secretary has adequate information from other sources, such as qualified clinical data registries, surgical logs, billing systems or other practice or facility records, and electronic health records, in order to accurately value global surgical services under this section.

(iii) Inspector general audit

The Inspector General of the Department of Health and Human Services shall audit a sample of the information reported under clause (i) to verify the accuracy of the information so reported.

(C) Improving accuracy of pricing for surgical services

For years beginning with 2019, the Secretary shall use the information reported under subparagraph (B)(i) as appropriate and other available data for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule under this section.

(d) Conversion factors

(1) Establishment

(A) In general

The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001 and ending with 2025, multiplied by the update (established under paragraph (4) or a subsequent paragraph) for the year involved. There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1395*l*(z)(2) of this title) (referred to in this subsection as the ''qualifying APM conversion factor'') and the other for other items and services (referred to in this subsection as the ''nonqualifying APM conversion factor''), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.

(B) Special provision for 1992

For purposes of subparagraph (A), the conversion factor specified in this subparagraph is a conversion factor (determined by the Secretary) which, if this section were to apply during 1991 using such conversion factor, would result in the same aggregate amount of payments under this part for physicians' services as the estimated aggregate amount of the payments under this part for such services in 1991.

(C) Special rules for 1998

Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.

(D) Special rules for anesthesia services

The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor (or, beginning with 2026, applicable conversion

factor) established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) Publication and dissemination of information

The Secretary shall—

(i) cause to have published in the Federal Register not later than November 1 of each year (beginning with 2000) the conversion factor which will apply to physicians' services for the succeeding year, the update determined under paragraph (4) for such succeeding year, and the allowed expenditures under such paragraph for such succeeding year; and

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(2) Repealed. Pub. L. 105–33, title IV, § 4502(b), Aug. 5, 1997, 111 Stat. 433

(3) Update for 1999 and 2000

(A) In general

Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for 1999 and 2000 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

(B) Update adjustment factor

For purposes of subparagraph (A)(ii), the ''update adjustment factor'' for a year is equal (as estimated by the Secretary) to—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(C) Determination of allowed expenditures

For purposes of this paragraph and paragraph (4), the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) Restriction on variation from medicare economic index

Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) − 1; or

(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) − 1,

where ''MEI percentage'' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year involved.

(4) Update for years beginning with 2001 and ending with 2014

(A) In general

Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 2001 and ending with 2014 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for the year (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under subparagraph (B) for the year.

(B) Update adjustment factor

For purposes of subparagraph (A)(ii), subject to subparagraph (D) and the succeeding paragraphs of this subsection, the ''update adjustment factor'' for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) Prior year adjustment component

An amount determined by—

(I) computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (as determined under subparagraph (C)) and the amount of the actual expenditures for such services for that year;

(II) dividing that difference by the amount of the actual expenditures for such services for that year; and

(III) multiplying that quotient by 0.75.

(ii) Cumulative adjustment component

An amount determined by—

(I) computing the difference (which may be positive or negative) between the

amount of the allowed expenditures for physicians' services (as determined under subparagraph (C)) from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

(III) multiplying that quotient by 0.33.

(C) Determination of allowed expenditures

For purposes of this paragraph:

(i) Period up to April 1, 1999

The allowed expenditures for physicians' services for a period before April 1, 1999, shall be the amount of the allowed expenditures for such period as determined under paragraph (3)(C).

(ii) Transition to calendar year allowed expenditures

Subject to subparagraph (E), the allowed expenditures for—

(I) the 9-month period beginning April 1, 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such period; and

(II) the year of 1999, shall be the Secretary's estimate of the amount of the allowed expenditures that would be permitted under paragraph (3)(C) for such year.

(iii) Years beginning with 2000

The allowed expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) Restriction on update adjustment factor

The update adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

(E) Recalculation of allowed expenditures for updates beginning with 2001

For purposes of determining the update adjustment factor for a year beginning with 2001, the Secretary shall recompute the allowed expenditures for previous periods beginning on or after April 1, 1999, consistent with subsection (f)(3).

(F) Transitional adjustment designed to provide for budget neutrality

Under this subparagraph the Secretary shall provide for an adjustment to the update under subparagraph (A)—

(i) for each of 2001, 2002, 2003, and 2004, of −0.2 percent; and

(ii) for 2005 of +0.8 percent.

(5) Update for 2004 and 2005

The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.

(6) Update for 2006

The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be 0 percent.

(7) Conversion factor for 2007

(A) In general

The conversion factor that would otherwise be applicable under this subsection for 2007 shall be the amount of such conversion factor divided by the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) for 2007 (divided by 100); and

(ii) 1 plus the Secretary's estimate of the update adjustment factor under paragraph (4)(B) for 2007.

(B) No effect on computation of conversion factor for 2008

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2008 as if subparagraph (A) had never applied.

(8) Update for 2008

(A) In general

Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, the update to the single conversion factor shall be 0.5 percent.

(B) No effect on computation of conversion factor for 2009

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2009 and subsequent years as if subparagraph (A) had never applied.

(9) Update for 2009

(A) In general

Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

(B) No effect on computation of conversion factor for 2010 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.

(10) Update for January through May of 2010

(A) In general

Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on January 1, 2010, and ending on May 31, 2010, the update to the single conversion factor shall be 0 percent for 2010.

(B) No effect on computation of conversion factor for remaining portion of 2010 and subsequent years

The conversion factor under this subsection shall be computed under paragraph

(1)(A) for the period beginning on June 1, 2010, and ending on December 31, 2010, and for 2011 and subsequent years as if subparagraph (A) had never applied.

(11) Update for June through December of 2010

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), and (10)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010 for the period beginning on June 1, 2010, and ending on December 31, 2010, the update to the single conversion factor shall be 2.2 percent.

(B) No effect on computation of conversion factor for 2011 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

(12) Update for 2011

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), and (11)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2011, the update to the single conversion factor shall be 0 percent.

(B) No effect on computation of conversion factor for 2012 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.

(13) Update for 2012

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), and (12)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2012, the update to the single conversion factor shall be zero percent.

(B) No effect on computation of conversion factor for 2013 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013 and subsequent years as if subparagraph (A) had never applied.

(14) Update for 2013

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2013, the update to the single conversion factor for such year shall be zero percent.

(B) No effect on computation of conversion factor for 2014 and subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied.

(15) Update for 2014

(A) In general

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014, the update to the single conversion factor shall be 0.5 percent.

(B) No effect on computation of conversion factor for subsequent years

The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2015 and subsequent years as if subparagraph (A) had never applied.

(16) Update for January through June of 2015

Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

(17) Update for July through December of 2015

The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

(18) Update for 2016 through 2019

The update to the single conversion factor established in paragraph (1)(C)—

(A) for 2016 and each subsequent year through 2018 shall be 0.5 percent; and

(B) for 2019 shall be 0.25 percent.

(19) Update for 2020 through 2025

The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

(20) Update for 2026 and subsequent years

For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.

(e) Geographic adjustment factors

(1) Establishment of geographic indices

(A) In general

Subject to subparagraphs (B), (C), (E), (G), (H), and (I), the Secretary shall establish—

(i) an index which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee schedule areas compared to the national average of such costs,

(ii) an index which reflects the relative costs of malpractice expenses in the different fee schedule areas compared to the national average of such costs, and

(iii) an index which reflects ¼ of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) Class-specific geographic cost-of-practice indices

The Secretary may establish more than one index under subparagraph (A)(i) in the

case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) Periodic review and adjustments in geographic adjustment factors

The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elasped[2] since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be ½ of the adjustment that otherwise would be made.

(D) Use of recent data

In establishing indices and index values under this paragraph, the Secretary shall use the most recent data available relating to practice expenses, malpractice expenses, and physician work effort in different fee schedule areas.

(E) Floor at 1.0 on work geographic index

After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2024, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

(G)[3] Floor for practice expense, malpractice, and work geographic indices for services furnished in Alaska

For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67. For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5[1]

(H) Practice expense geographic adjustment for 2010 and subsequent years

(i) For 2010

Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(ii) For 2011

Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

(iii) Hold harmless

The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

(iv) Analysis

The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

(v) Revision for 2012 and subsequent years

As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

(II) considering a representative range of professional and non-professional personnel employed in a medical office

[2] So in original. Probably should be ''elapsed''.

[3] So in original. No subpar. (F) has been enacted.

based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

(I) Floor for practice expense index for services furnished in frontier States

(i) In general

Subject to clause (ii), for purposes of payment for services furnished in a frontier State (as defined in section 1395ww(d)(3)(E)(iii)(II) of this title) on or after January 1, 2011, after calculating the practice expense index in subparagraph (A)(i), the Secretary shall increase any such index to 1.00 if such index would otherwise be less that[4] 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(ii) Limitation

This subparagraph shall not apply to services furnished in a State that receives a non-labor related share adjustment under section 1395ww(d)(5)(H) of this title.

(2) Computation of geographic adjustment factor

For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the geographic physician work adjustment factor (specified in paragraph (5)) for the service and the area.

(3) Geographic cost-of-practice adjustment factor

For purposes of paragraph (2), the ''geographic cost-of-practice adjustment factor'', for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the practice expense component, and

(B) the geographic cost-of-practice index value for the area for the service, based on the index established under paragraph (1)(A)(i) or (1)(B) (as the case may be).

(4) Geographic malpractice adjustment factor

For purposes of paragraph (2), the ''geographic malpractice adjustment factor'', for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the malpractice component, and

(B) the geographic malpractice index value for the area, based on the index established under paragraph (1)(A)(ii).

(5) Geographic physician work adjustment factor

For purposes of paragraph (2), the ''geographic physician work adjustment factor'', for a service for a fee schedule area, is the product of—

(A) the proportion of the total relative value for the service that reflects the relative value units for the work component, and

(B) the geographic physician work index value for the area, based on the index established under paragraph (1)(A)(iii).

(6) Use of MSAs as fee schedule areas in California

(A) In general

Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an ''MSA''), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

(B) Transition for MSAs previously in rest-of-state payment locality or in locality 3

(i) In general

For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) Current law component

The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-based component

The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

(ii) Old weighting factor

The old weighting factor described in this clause—

(I) for 2017, is 5⁄6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1⁄6.

[4] So in original. Probably should be ''than''.

(iii) MSA-based weighting factor

The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) Hold harmless

For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) Transition area defined

In this paragraph, the term ''transition area'' means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) References to fee schedule areas

Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) Sustainable growth rate

(1) Publication

The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; and

(B) November 1 of each succeeding year through 2014 the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) Specification of growth rate

The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 and ending with 2014 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous applicable period to the applicable period involved,

(C) 1 plus the Secretary's estimate of the annual average percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved, and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be,

minus 1 and multiplied by 100.

(3) Data to be used

For purposes of determining the update adjustment factor under subsection (d)(4)(B) for a year beginning with 2001, the sustainable growth rates taken into consideration in the determination under paragraph (2) shall be determined as follows:

(A) For 2001

For purposes of such calculations for 2001, the sustainable growth rates for fiscal year 2000 and the years 2000 and 2001 shall be determined on the basis of the best data available to the Secretary as of September 1, 2000.

(B) For 2002

For purposes of such calculations for 2002, the sustainable growth rates for fiscal year 2000 and for years 2000, 2001, and 2002 shall be determined on the basis of the best data available to the Secretary as of September 1, 2001.

(C) For 2003 and succeeding years

For purposes of such calculations for a year after 2002—

(i) the sustainable growth rates for that year and the preceding 2 years shall be determined on the basis of the best data available to the Secretary as of September 1 of the year preceding the year for which the calculation is made; and

(ii) the sustainable growth rate for any year before a year described in clause (i) shall be the rate as most recently determined for that year under this subsection.

Nothing in this paragraph shall be construed as affecting the sustainable growth rates established for fiscal year 1998 or fiscal year 1999.

(4) Definitions

In this subsection:

(A) Services included in physicians' services

The term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

(B) Medicare+Choice plan enrollee

The term ''Medicare+Choice plan enrollee'' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this subchapter for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1395mm of this title.

(C) Applicable period

The term ''applicable period'' means—

(i) a fiscal year, in the case of fiscal year 1998, fiscal year 1999, and fiscal year 2000; or

(ii) a calendar year with respect to a year beginning with 2000;

as the case may be.

(g) Limitation on beneficiary liability

(1) Limitation on actual charges

(A) In general

In the case of a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) who does not accept payment on an assignment-related basis for a physician's service furnished with respect to an individual enrolled under this part, the following rules apply:

(i) Application of limiting charge

No person may bill or collect an actual charge for the service in excess of the limiting charge described in paragraph (2) for such service.

(ii) No liability for excess charges

No person is liable for payment of any amounts billed for the service in excess of such limiting charge.

(iii) Correction of excess charges

If such a physician, supplier, or other person bills, but does not collect, an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall reduce on a timely basis the actual charge billed for the service to an amount not to exceed the limiting charge for the service.

(iv) Refund of excess collections

If such a physician, supplier, or other person collects an actual charge for a service in violation of clause (i), the physician, supplier, or other person shall provide on a timely basis a refund to the individual charged in the amount by which the amount collected exceeded the limiting charge for the service. The amount of such a refund shall be reduced to the extent the individual has an outstanding balance owed by the individual to the physician.

(B) Sanctions

If a physician, supplier, or other person—

(i) knowingly and willfully bills or collects for services in violation of subparagraph (A)(i) on a repeated basis, or

(ii) fails to comply with clause (iii) or (iv) of subparagraph (A) on a timely basis,

the Secretary may apply sanctions against the physician, supplier, or other person in accordance with paragraph (2) of section 1395u(j) of this title. In applying this subparagraph, paragraph (4) of such section applies in the same manner as such paragraph applies to such section and any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.

(C) Timely basis

For purposes of this paragraph, a correction of a bill for an excess charge or refund of an amount with respect to a violation of subparagraph (A)(i) in the case of a service is considered to be provided ''on a timely basis'', if the reduction or refund is made not later than 30 days after the date the physician, supplier, or other person is notified by the carrier under this part of such violation and of the requirements of subparagraph (A).

(2) "Limiting charge" defined

(A) For 1991

For physicians' services of a physician furnished during 1991, other than radiologist services subject to section 1395m(b) of this title, the ''limiting charge'' shall be the same percentage (or, if less, 25 percent) above the recognized payment amount under this part with respect to the physician (as a nonparticipating physician) as the percentage by which—

(i) the maximum allowable actual charge (as determined under section 1395u(j)(1)(C) of this title as of December 31, 1990, or, if less, the maximum actual charge otherwise permitted for the service under this part as of such date) for the service of the physician, exceeds

(ii) the recognized payment amount for the service of the physician (as a nonparticipating physician) as of such date.

In the case of evaluation and management services (as specified in section 1395u(b)(16)(B)(ii) of this title), the preceding sentence shall be applied by substituting ''40 percent'' for ''25 percent''.

(B) For 1992

For physicians' services furnished during 1992, other than radiologist services subject to section 1395m(b) of this title, the ''limiting charge'' shall be the same percentage (or, if less, 20 percent) above the recognized payment amount under this part for nonparticipating physicians as the percentage by which—

(i) the limiting charge (as determined under subparagraph (A) as of December 31, 1991) for the service, exceeds

(ii) the recognized payment amount for the service for nonparticipating physicians as of such date.

(C) After 1992

For physicians' services furnished in a year after 1992, the ''limiting charge'' shall be 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons.

(D) Recognized payment amount

In this section, the term ''recognized payment amount'' means, for services furnished on or after January 1, 1992, the fee schedule amount determined under subsection (a) (or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis), and, for services furnished during 1991, the applicable percentage (as defined in section 1395u(b)(4)(A)(iv) of this title) of the prevailing charge (or fee schedule amount)

for nonparticipating physicians for that year.

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX may only be made on an assignment-related basis and the provisions of section 1396a(n)(3)(A) of this title apply to further limit permissible charges under this section.

(B) Penalty

A person may not bill for physicians' services subject to subparagraph (A) other than on an assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 1395u(j)(2) of this title.

(4) Physician submission of claims

(A) In general

For services furnished on or after September 1, 1990, within 1 year after the date of providing a service for which payment is made under this part on a reasonable charge or fee schedule basis, a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title)—

(i) shall complete and submit a claim for such service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary, and

(ii) may not impose any charge relating to completing and submitting such a form.

(B) Penalty

(i) With respect to an assigned claim wherever a physician, provider, supplier or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit such a claim as required in subparagraph (A), the Secretary shall reduce by 10 percent the amount that would otherwise be paid for such claim under this part.

(ii) If a physician, supplier, or other person (or an employer or facility in the cases described in section 1395u(b)(6)(A) of this title) fails to submit a claim required to be submitted under subparagraph (A) or imposes a charge in violation of such subparagraph, the Secretary shall apply the sanction with respect to such a violation in the same manner as a sanction may be imposed under section 1395u(p)(3) of this title for a violation of section 1395u(p)(1) of this title.

(5) Electronic billing; direct deposit

The Secretary shall encourage and develop a system providing for expedited payment for claims submitted electronically. The Secretary shall also encourage and provide incentives allowing for direct deposit as payments for services furnished by participating physicians. The Secretary shall provide physicians with such technical information as necessary to enable such physicians to submit claims electronically. The Secretary shall submit a plan to Congress on this paragraph by May 1, 1990.

(6) Monitoring of charges

(A) In general

The Secretary shall monitor—

(i) the actual charges of nonparticipating physicians for physicians' services furnished on or after January 1, 1991, to individuals enrolled under this part, and

(ii) changes (by specialty, type of service, and geographic area) in (I) the proportion of expenditures for physicians' services provided under this part by participating physicians, (II) the proportion of expenditures for such services for which payment is made under this part on an assignment-related basis, and (III) the amounts charged above the recognized payment amounts under this part.

(B) Report

The Secretary shall, by not later than April 15 of each year (beginning in 1992), report to the Congress information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information regarding the changes described in subparagraph (A)(ii).

(C) Plan

If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The Medicare Payment Advisory Commission shall review the Secretary's plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) Monitoring of utilization and access

(A) In general

The Secretary shall monitor—

(i) changes in the utilization of and access to services furnished under this part within geographic, population, and service related categories,

(ii) possible sources of inappropriate utilization of services furnished under this part which contribute to the overall level of expenditures under this part, and

(iii) factors underlying these changes and their interrelationships.

(B) Report

The Secretary shall by not later than April 15,[5] of each year (beginning with 1991)

[5] So in original. The comma probably should not appear.

report to the Congress on the changes described in subparagraph (A)(i) and shall include in the report an examination of the factors (including factors relating to different services and specific categories and groups of services and geographic and demographic variations in utilization) which may contribute to such changes.

(C) Recommendations

The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The Medicare Payment Advisory Commission shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

(h) Sending information to physicians

Before the beginning of each year (beginning with 1992), the Secretary shall send to each physician or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3)) furnishing physicians' services under this part, for services commonly performed by the physician, supplier, or other person, information on fee schedule amounts that apply for the year in the fee schedule area for participating and non-participating physicians, and the maximum amount that may be charged consistent with subsection (g)(2). Such information shall be transmitted in conjunction with notices to physicians, suppliers, and other persons under section 1395u(h) of this title (relating to the participating physician program) for a year.

(i) Miscellaneous provisions

(1) Restriction on administrative and judicial review

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

(A) the determination of the adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)),

(B) the determination of relative values and relative value units under subsection (c), including adjustments under subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I) and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993,

(C) the determination of conversion factors under subsection (d), including without limitation a prospective redetermination of the sustainable growth rates for any or all previous fiscal years,

(D) the establishment of geographic adjustment factors under subsection (e),

(E) the establishment of the system for the coding of physicians' services under this section, and

(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).

(2) Assistants-at-surgery

(A) In general

Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

(B) Denial of payment in certain cases

If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.

(3) No comparability adjustment

For physicians' services for which payment under this part is determined under this section—

(A) a carrier may not make any adjustment in the payment amount under section 1395u(b)(3)(B) of this title on the basis that the payment amount is higher than the charge applicable, for comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

(B) no payment adjustment may be made under section 1395u(b)(8) of this title, and

(C) section 1395u(b)(9) of this title shall not apply.

(j) Definitions

In this section:

(1) Category

For services furnished before January 1, 1998, the term ''category'' means, with respect to physicians' services, surgical services, and all physicians' services other than surgical services (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title), and all other physicians' services. The Secretary shall define surgical services and publish such definition in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians.

(2) Fee schedule area

Except as provided in subsection (e)(6)(D), the term ''fee schedule area'' means a locality used under section 1395u(b) of this title for purposes of computing payment amounts for physicians' services.

(3) Physicians' services

The term ''physicians' services'' includes items and services described in paragraphs (1),

(2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1395x(*oo*)(2) of this title), (2)(R) (with respect to services described in subparagraphs (B), (C), and (D) of section 1395x(pp)(1) of this title), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), (3), (4), (13), (14) (with respect to services described in section 1395x(nn)(2) of this title), and (15) of section 1395x(s) of this title (other than clinical diagnostic laboratory tests and, except for purposes of subsections (a)(3), (g), and (h)[6] such other items and services as the Secretary may specify).

(4) Practice expenses

The term ''practice expenses'' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.

(k) Quality reporting system

(1) In general

The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

(2) Use of consensus-based quality measures

(A) For 2007

(i) In general

For purposes of applying this subsection for the reporting of data on quality measures for covered professional services furnished during the period beginning July 1, 2007, and ending December 31, 2007, the quality measures specified under this paragraph are the measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of December 20, 2006, except as may be changed by the Secretary based on the results of a consensus-based process in January of 2007, if such change is published on such website by not later than April 1, 2007.

(ii) Subsequent refinements in application permitted

The Secretary may, from time to time (but not later than July 1, 2007), publish on such website (without notice or opportunity for public comment) modifications or refinements (such as code additions, corrections, or revisions) for the application of quality measures previously published under clause (i), but may not, under this clause, change the quality measures under the reporting system.

(iii) Implementation

Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection for 2007.

(B) For 2008 and 2009

(i) In general

For purposes of reporting data on quality measures for covered professional services furnished during 2008 and 2009, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.

(ii) Proposed set of measures

Not later than August 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable. The Secretary shall provide for a period of public comment on such set of measures.

(iii) Final set of measures

Not later than November 15 of each of 2007 and 2008, the Secretary shall publish in the Federal Register a final set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008 or 2009, as applicable.

(C) For 2010 and subsequent years

(i) In general

Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(ii) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

[6] So in original. Probably should be followed by a comma.

(D) Opportunity to provide input on measures for 2009 and subsequent years

For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.

(3) Covered professional services and eligible professionals defined

For purposes of this subsection:

(A) Covered professional services

The term ''covered professional services'' means services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional.

(B) Eligible professional

The term ''eligible professional'' means any of the following:

(i) A physician.

(ii) A practitioner described in section 1395u(b)(18)(C) of this title.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) Beginning with 2009, a qualified audiologist (as defined in section 1395x(*ll*)(3)(B) of this title).

(4) Use of registry-based reporting

As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry, as identified by the Secretary.

(5) Identification units

For purposes of applying this subsection, the Secretary may identify eligible professionals through billing units, which may include the use of the Provider Identification Number, the unique physician identification number (described in section 1395*l*(q)(1) of this title), the taxpayer identification number, or the National Provider Identifier. For purposes of applying this subsection for 2007, the Secretary shall use the taxpayer identification number as the billing unit.

(6) Education and outreach

The Secretary shall provide for education and outreach to eligible professionals on the operation of this subsection.

(7) 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 the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

(8) Implementation

The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare & Medicaid Services.

(9) Continued application for purposes of MIPS and for certain professionals volunteering to report

The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

***(l)* Physician Assistance and Quality Initiative Fund**

(1) Establishment

The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the ''Fund'') which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

(2) Funding

(A) Amount available

(i) In general

Subject to clause (ii), there shall be available to the Fund the following amounts:

(I) For expenditures during 2008, an amount equal to $150,500,000.

(II) For expenditures during 2009, an amount equal to $24,500,000.

(ii) Limitations on expenditures

(I) 2008

The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(II) 2009

The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

(B) Timely obligation of all available funds for services

The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

(i) 2008 for payment with respect to physicians' services furnished during 2008; and

(ii) 2009 for payment with respect to physicians' services furnished during 2009.

(C) Payment from Trust Fund

The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title.

(D) Funding limitation

Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). 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.

(E) Construction

In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.

(m) Incentive payments for quality reporting

(1) Incentive payments

(A) In general

For 2007 through 2014, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

(i) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such reporting period; and

(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to the applicable quality percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) Applicable quality percent

For purposes of subparagraph (A), the term ''applicable quality percent'' means—

(i) for 2007 and 2008, 1.5 percent;
(ii) for 2009 and 2010, 2.0 percent;
(iii) for 2011, 1.0 percent; and
(iv) for 2012, 2013, and 2014, 0.5 percent.

(2) Incentive payments for electronic prescribing

(A) In general

Subject to subparagraph (D), for 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to the applicable electronic prescribing percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

(B) Limitation with respect to electronic prescribing quality measures

The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or the group, as applicable); or

(ii) if determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under part D.

If the Secretary makes the determination to apply clause (ii) for a period, then clause (i) shall not apply for such period.

(C) Applicable electronic prescribing percent

For purposes of subparagraph (A), the term ''applicable electronic prescribing percent'' means—

(i) for 2009 and 2010, 2.0 percent;
(ii) for 2011 and 2012, 1.0 percent; and
(iii) for 2013, 0.5 percent.

(D) Limitation with respect to EHR incentive payments

The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (*o*)(1)(A) with respect to a certified EHR technology (as defined in subsection (*o*)(4)) that has the capability of electronic prescribing.

(3) Satisfactory reporting and successful electronic prescriber described

(A) In general

For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of subsection (a)(8), for the quality reporting period for the year) if quality measures have been reported as follows:

(i) Three or fewer quality measures applicable

If there are no more than 3 quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, each such quality measure has been reported under such system in at least 80 percent of the cases in which such measure is reportable under the system.

(ii) Four or more quality measures applicable

If there are 4 or more quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, at least 3 such quality measures have been reported under such system in at least 80 percent of the cases in which the respective measure is reportable under the system.

For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures.

(B) Successful electronic prescriber

(i) In general

For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the requirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (iii) for a period, then the requirement described in clause (ii) shall not apply for such period.

(ii) Requirement for submitting data on electronic prescribing quality measures

The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

(iii) Requirement for electronically prescribing under part D

The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

(iv) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of clause (iii), paragraph (2)(B)(ii), and paragraph (5)(G).

(v) Standards for electronic prescribing

To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1395w–104(e) of this title.

(C) Satisfactory reporting measures for group practices

(i) In general

By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year), or, for purposes of subsection (a)(8), for a quality reporting period for the year if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-

cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

(ii) Statistical sampling model

The process under clause (i) shall provide and, for 2016 and subsequent years, may provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1395cc–1 of this title.

(iii) No double payments

Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

(D) Satisfactory reporting measures through participation in a qualified clinical data registry

For 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) and, for 2016 and subsequent years, subparagraph (A) or (C) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

(E) Qualified clinical data registry

(i) In general

The Secretary shall establish requirements for an entity to be considered a qualified clinical data registry. Such requirements shall include a requirement that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out this subsection.

(ii) Considerations

In establishing the requirements under clause (i), the Secretary shall consider whether an entity—

(I) has in place mechanisms for the transparency of data elements and specifications, risk models, and measures;

(II) requires the submission of data from participants with respect to multiple payers;

(III) provides timely performance reports to participants at the individual participant level; and

(IV) supports quality improvement initiatives for participants.

(iii) Measures

With respect to measures used by a qualified clinical data registry—

(I) sections 1395aaa(b)(7) and 1395aaa–1(a) of this title shall not apply; and

(II) measures endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title may be used.

(iv) Consultation

In carrying out this subparagraph, the Secretary shall consult with interested parties.

(v) Determination

The Secretary shall establish a process to determine whether or not an entity meets the requirements established under clause (i). Such process may involve one or both of the following:

(I) A determination by the Secretary.

(II) A designation by the Secretary of one or more independent organizations to make such determination.

(F) Authority to revise satisfactorily reporting data

For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).

(4) Form of payment

The payment under this subsection shall be in the form of a single consolidated payment.

(5) Application

(A) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) Coordination with other bonus payments

The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) of section 1395*l* of this title and any payment under such subsections shall not be taken into account in computing allowable charges under this subsection.

(C) Implementation

Notwithstanding any other provision of law, for 2007, 2008, and 2009, the Secretary may implement by program instruction or otherwise this subsection.

(D) Validation

(i) In general

Subject to the succeeding provisions of this subparagraph, for purposes of determining whether a measure is applicable to the covered professional services of an eligible professional under this subsection for 2007 and 2008, the Secretary shall presume that if an eligible professional submits data for a measure, such measure is applicable to such professional.

(ii) Method

The Secretary may establish procedures to validate (by sampling or other means as the Secretary determines to be appropriate) whether measures applicable to covered professional services of an eligible professional have been reported.

(iii) Denial of payment authority

If the Secretary determines that an eligible professional (or, in the case of a

group practice under paragraph (3)(C), the group practice) has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the incentive payment under this subsection. If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).

(E) Limitations on review

Except as provided in subparagraph (I), there shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of—

(i) the determination of measures applicable to services furnished by eligible professionals under this subsection;

(ii) the determination of satisfactory reporting under this subsection;

(iii) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and

(iv) the determination of any incentive payment under this subsection and the payment adjustment under paragraphs (5)(A) and (8)(A) of subsection (a).

(F) Extension

For 2008 through reporting periods occurring in 2015, the Secretary shall establish and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish alternative criteria for satisfactorily reporting under this subsection and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

(G) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.

(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.

(H) Feedback

The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.

(I) Informal appeals process

The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.

(6) Definitions

For purposes of this subsection:

(A) Eligible professional; covered professional services

The terms ''eligible professional'' and ''covered professional services'' have the meanings given such terms in subsection (k)(3).

(B) Physician reporting system

The term ''physician reporting system'' means the system established under subsection (k).

(C) Reporting period

(i) In general

Subject to clauses (ii) and (iii), the term ''reporting period'' means—

(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

(II) for 2008 and subsequent years, the entire year.

(ii) Authority to revise reporting period

For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term ''reporting period'' shall mean such revised period.

(iii) Reference

Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) (a)(8)[7] shall be deemed a reference to the reporting period under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii),[8] respectively.

(7) Integration of physician quality reporting and EHR reporting

Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (*o*) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

(A) The selection of measures, the reporting of which would both demonstrate—

(i) meaningful use of an electronic health record for purposes of subsection (*o*); and

(ii) quality of care furnished to an individual.

(B) Such other activities as specified by the Secretary.

(8) Additional incentive payment

(A) In general

For 2011 through 2014, if an eligible professional meets the requirements described in

[7] So in original.

[8] So in original. Probably should be ''(a)(8)(C)(iii),''.

subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

(B) Requirements described

In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

(i) The eligible professional shall—

(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) an alternative form and manner determined appropriate by the Secretary.

(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

(I) participates in such a Maintenance of Certification program for a year; and

(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);

(II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and

(III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.

(C) Definitions

For purposes of this paragraph:

(i) The term ''Maintenance of Certification Program'' means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(I) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(II) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(III) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(IV) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (ii).

(ii) The term ''qualified Maintenance of Certification Program practice assessment'' means an assessment of a physician's practice that—

(I) includes an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(II) includes a survey of patient experience with care; and

(III) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention.

(9) Continued application for purposes of MIPS and for certain professionals volunteering to report

The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

(A) for purposes of subsection (q); and

(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.

(n) Physician Feedback Program

(1) Establishment

(A) In general

(i) Establishment

The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the ''Program'').

(ii) Reports on resources

The Secretary shall use claims data under this subchapter (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this subchapter.

(iii) Inclusion of certain information

If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this subchapter by the physician (or group of physicians) in such reports.

(B) Resource use

The resources described in subparagraph (A)(ii) may be measured—

(i) on an episode basis;
(ii) on a per capita basis; or
(iii) on both an episode and a per capita basis.

(2) Implementation

The Secretary shall implement the Program by not later than January 1, 2009.

(3) Data for reports

To the extent practicable, reports under the Program shall be based on the most recent data available.

(4) Authority to focus initial application

The Secretary may focus the initial application of the Program as appropriate, such as focusing the Program on—

(A) physician specialties that account for a certain percentage of all spending for physicians' services under this subchapter;

(B) physicians who treat conditions that have a high cost or a high volume, or both, under this subchapter;

(C) physicians who use a high amount of resources compared to other physicians;

(D) physicians practicing in certain geographic areas; or

(E) physicians who treat a minimum number of individuals under this subchapter.

(5) Authority to exclude certain information if insufficient information

The Secretary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

(6) Adjustment of data

To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take into account variations in health status and other patient characteristics. For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.

(7) Education and outreach

The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

(8) Disclosure exemption

Reports under the Program shall be exempt from disclosure under section 552 of title 5.

(9) Reports on utilization

(A) Development of episode grouper

(i) In general

The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

(ii) Timeline for development

The episode grouper described in subparagraph (A)[9] shall be developed by not later than January 1, 2012.

(iii) Public availability

The Secretary shall make the details of the episode grouper described in subparagraph (A)[9] available to the public.

(iv) Endorsement

The Secretary shall seek endorsement of the episode grouper described in subparagraph (A)[9] by the entity with a contract under section 1395aaa(a) of this title.

(B) Reports on utilization

Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

(C) Analysis of data

The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

(i) attribute episodes of care, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

(D) Data adjustment

In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

(E) Public availability of methodology

The Secretary shall make available to the public—

(i) the methodologies established under subparagraph (C);

(ii) information regarding any adjustments made to data under subparagraph (D); and

(iii) aggregate reports with respect to physicians.

(F) Definition of physician

In this paragraph:

(i) In general

The term ''physician'' has the meaning given that term in section 1395x(r)(1) of this title.

(ii) Treatment of groups

Such term includes, as the Secretary determines appropriate, a group of physicians.

(G) Limitations on review

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

[9] So in original. Probably means cl. (i) of this subpar.

section 1395*oo* of this title, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

(10) Coordination with other value-based purchasing reforms

The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this subchapter.

(11) Reports ending with 2017

Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.

(*o*) Incentives for adoption and meaningful use of certified EHR technology

(1) Incentive payments

(A) In general

(i) In general

Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1395u(b)(6) of this title), from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

(ii) No incentive payments with respect to years after 2016

No incentive payments may be made under this subsection with respect to a year after 2016.

(B) Limitations on amounts of incentive payments

(i) In general

In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

(ii) Amount

Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

(I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).

(II) For the second payment year for such professional, $12,000.

(III) For the third payment year for such professional, $8,000.

(IV) For the fourth payment year for such professional, $4,000.

(V) For the fifth payment year for such professional, $2,000.

(VI) For any succeeding payment year for such professional, $0.

(iii) Phase down for eligible professionals first adopting EHR after 2013

If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

(iv) Increase for certain eligible professionals

In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 254e(a)(1)(A) of this title) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1395*l* of this title in a similar manner as such provisions apply under such subsection.

(v) No incentive payment if first adopting after 2014

If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

(C) Non-application to hospital-based eligible professionals

(i) In general

No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

(ii) Hospital-based eligible professional

For purposes of clause (i), the term ''hospital-based eligible professional'' means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination

of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(D) Payment

(i) Form of payment

The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(ii) Coordination of application of limitation for professionals in different practices

In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

(iii) Coordination with Medicaid

The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this subchapter and subchapter XIX. The Secretary may also adjust the reporting periods under such subchapter and such subsections in order to carry out this clause.

(E) Payment year defined

(i) In general

For purposes of this subsection, the term ''payment year'' means a year beginning with 2011.

(ii) First, second, etc. payment year

The term ''first payment year'' means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms ''second payment year'', ''third payment year'', ''fourth payment year'', and ''fifth payment year'' mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

(2) Meaningful EHR user

(A) In general

An eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year) if each of the following requirements is met:

(i) Meaningful use of certified EHR technology

The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

(ii) Information exchange

The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

(iii) Reporting on measures using EHR

Subject to subparagraph (B)(ii) and subsection (q)(5)(B)(ii)(II) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time.

(B) Reporting on measures

(i) Selection

The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1395aaa(a) of this title.

(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

(ii) Limitation

The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph

(A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

(iii) Coordination of reporting of information

In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

(C) Demonstration of meaningful use of certified EHR technology and information exchange

(i) In general

A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

(I) an attestation;

(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

(III) a survey response;

(IV) reporting under subparagraph (A)(iii); and

(V) other means specified by the Secretary.

(ii) Use of part D data

Notwithstanding sections 1395w–115(d)(2)(B) and 1395w–115(f)(2) of this title, the Secretary may use data regarding drug claims submitted for purposes of section 1395w–115 of this title that are necessary for purposes of subparagraph (A).

(D) Continued application for purposes of MIPS

With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year. The provisions of subparagraphs (B) and (D) of subsection (a)(7),[5] shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).

(3) Application

(A) Physician reporting system rules

Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

(B) Coordination with other payments

The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1395*l*(m) of this title and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection.

(C) 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—

(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D);

(ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B);

(iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and

(iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i).

(D) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

(4) Certified EHR technology defined

For purposes of this section, the term ''certified EHR technology'' means a qualified electronic health record (as defined in section 300jj(13) of this title) that is certified pursuant to section 300jj–11(c)(5) of this title as meeting standards adopted under section 300jj–14 of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(5) Definitions

For purposes of this subsection:

(A) Covered professional services

The term ''covered professional services'' has the meaning given such term in subsection (k)(3).

(B) EHR reporting period

The term ''EHR reporting period'' means, with respect to a payment year, any period (or periods) as specified by the Secretary.

(C) Eligible professional

The term ''eligible professional'' means a physician, as defined in section 1395x(r) of this title.

(p) Establishment of value-based payment modifier

(1) In general

The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) Quality

(A) In general

For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

(B) Measures

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1395aaa(a) of this title.

(C) Continued application for purposes of MIPS

The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).

(3) Costs

For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions)[10] and other factors determined appropriate by the Secretary. With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).

(4) Implementation

(A) Publication of measures, dates of implementation, performance period

Not later than January 1, 2012, the Secretary shall publish the following:

(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

(iii) The initial performance period (as specified under subparagraph (B)(ii)).

(B) Deadlines for implementation

(i) Initial implementation

Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

(ii) Initial performance period

(I) In general

The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

(II) Provision of information during initial performance period

During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

(iii) Application

The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2019.

(C) Budget neutrality

The payment modifier established under this subsection shall be implemented in a budget neutral manner.

(5) Systems-based care

The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

(6) Consideration of special circumstances of certain providers

In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

(7) Application

For purposes of the initial application of the payment modifier established under this subsection during the period beginning on Janu-

[10] So in original. Probably should be followed by a second closing parenthesis.

ary 1, 2015, and ending on December 31, 2016, the term ''physician'' has the meaning given such term in section 1395x(r) of this title. On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

(8) Definitions

For purposes of this subsection:

(A) Costs

The term ''costs'' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

(B) Performance period

The term ''performance period'' means a period specified by the Secretary.

(9) Coordination with other value-based purchasing reforms

The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this subchapter.

(10) 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—

(A) the establishment of the value-based payment modifier under this subsection;

(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

(D) the dates for implementation of the value-based payment modifier;

(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

(F) the application of the value-based payment modifier under paragraph (7); and

(G) the determination of costs under paragraph (8)(A).

(q) Merit-based Incentive Payment System

(1) Establishment

(A) In general

Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the ''MIPS'') under which the Secretary shall—

(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

Notwithstanding subparagraph (C)(ii), under the MIPS, the Secretary shall permit any eligible professional (as defined in subsection (k)(3)(B)) to report on applicable measures and activities described in paragraph (2)(B).

(B) Program implementation

The MIPS shall apply to payments for covered professional services (as defined in subsection (k)(3)(A)) furnished on or after January 1, 2019.

(C) MIPS eligible professional defined

(i) In general

For purposes of this subsection, subject to clauses (ii) and (iv), the term ''MIPS eligible professional'' means—

(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1395x(r) of this title), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title), a certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title), and a group that includes such professionals; and

(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

(ii) Exclusions

For purposes of clause (i), the term ''MIPS eligible professional'' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

(I) is a qualifying APM participant (as defined in section 1395*l*(z)(2) of this title);

(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

(iii) Partial qualifying APM participant

For purposes of this subparagraph, the term ''partial qualifying APM participant'' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1395*l*(z) of this title for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

(I) with respect to 2019 and 2020, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

(II) with respect to each of 2021 through 2024—

(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph[7] were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2025 and subsequent years—

(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph[7] were instead references to 50 percent and 20 percent, respectively.

(iv) Selection of low-volume threshold measurement

The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

(I) The minimum number (as determined by the Secretary) of—

(aa) for performance periods beginning before January 1, 2018, individuals enrolled under this part who are treated by the eligible professional for the performance period involved; and

(bb) for performance periods beginning on or after January 1, 2018, individuals enrolled under this part who are furnished covered professional services (as defined in subsection (k)(3)(A)) by the eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of covered professional services (as defined in subsection (k)(3)(A)) furnished to individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of—

(aa) for performance periods beginning before January 1, 2018, allowed charges billed by such professional under this part for such performance period; and

(bb) for performance periods beginning on or after January 1, 2018, allowed charges for covered professional services (as defined in subsection (k)(3)(A)) billed by such professional for such performance period.

(v) Treatment of new Medicare enrolled eligible professionals

In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this subchapter such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

(vi) Clarification

In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

(vii) Partial qualifying APM participant clarifications

(I) Treatment as MIPS eligible professional

In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who, for the performance period for such year, reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

(II) Not eligible for qualifying APM participant payments

In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1395*l*(z) of this title) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

(D) Application to group practices

(i) In general

Under the MIPS:

(I) Quality performance category

The Secretary shall establish and apply a process that includes features of

the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

(II) Other performance categories

The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

(ii) Ensuring comprehensiveness of group practice assessment

The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

(E) Use of registries

Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

(F) Application of certain provisions

In applying a provision of subsection (k), (m), (*o*), or (p) for purposes of this subsection, the Secretary shall—

(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

(G) Accounting for risk factors

(i) Risk factors

Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

(2) Measures and activities under performance categories

(A) Performance categories

Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

(i) Quality.

(ii) Resource use.

(iii) Clinical practice improvement activities.

(iv) Meaningful use of certified EHR technology.

(B) Measures and activities specified for each category

For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

(i) Quality

For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

(ii) Resource use

For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

(iii) Clinical practice improvement activities

For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms. This subcategory shall include as an activity, for performance periods beginning on or after January 1, 2022, use of a real-time benefit tool as described in section 1395w–104(*o*) of this title. The Secretary

may establish this activity as a standalone or as a component of another activity.

(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

(VI) The subcategory of participation in an alternative payment model (as defined in section 1395*l*(z)(3)(C) of this title).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 254e(a)(1)(A) of this title).

(iv) Meaningful EHR use

For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (*o*)(2) for determining whether an eligible professional is a meaningful EHR user.

(C) Additional provisions

(i) Emphasizing outcome measures under the quality performance category

In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

(ii) Application of additional system measures

The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

(iii) Global and population-based measures

The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

(iv) Application of measures and activities to non-patient-facing professionals

In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

(v) Clinical practice improvement activities

(I) Request for information

In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

(II) Contract authority for clinical practice improvement activities performance category

In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

(aa) identifying activities described in subparagraph (B)(iii);

(bb) specifying criteria for such activities; and

(cc) determining whether a MIPS eligible professional meets such criteria.

(III) Clinical practice improvement activities defined

For purposes of this subsection, the term ''clinical practice improvement activity'' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

(D) Annual list of quality measures available for MIPS assessment

(i) In general

Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

(bb) adding to such list, as appropriate, new quality measures; and

(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

(ii) Call for quality measures

(I) In general

Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1395aaa(a) of this title.

(II) Eligible professional organization defined

In this subparagraph, the term ''eligible professional organization'' means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) Requirements

In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

(iv) Peer review

Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate, peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

(v) Measures for inclusion

The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

(I) measures endorsed by a consensus-based entity;

(II) measures developed under subsection (s); and

(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

(vi) Exception for qualified clinical data registry measures

Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

(vii) Exception for existing quality measures

Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or performance period under the respective subsection beginning before the first performance period under the MIPS—

(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

(viii) Consultation with relevant eligible professional organizations and other relevant stakeholders

Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

(ix) Optional application

The process under section 1395aaa–1 of this title is not required to apply to the selection of measures under this subparagraph.

(3) Performance standards

(A) Establishment

Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

(B) Considerations in establishing standards

In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

(i) Historical performance standards.

(ii) Improvement.

(iii) The opportunity for continued improvement.

(4) Performance period

The Secretary shall establish a performance period (or periods) for a year (beginning with

2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

(5) Composite performance score

(A) In general

Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the ''composite performance score'' for such professional for such performance period.

(B) Incentive to report; encouraging use of certified EHR technology for reporting quality measures

(i) Incentive to report

Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

(ii) Encouraging use of certified EHR technology and qualified clinical data registries for reporting quality measures

Under the methodology established under subparagraph (A), the Secretary shall—

(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (*o*)(2)(A)(iii) for such year.

(C) Clinical practice improvement activities performance score

(i) Rule for certification

A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM participation

Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1395*l*(z)(3)(C) of this title) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

(iii) Subcategories

A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

(D) Achievement and improvement

(i) Taking into account improvement

Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), subject to clause (iii), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) Assigning higher weight for achievement

Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

(iii) Transition years

For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, the performance score for the performance category described in paragraph (2)(A)(ii) shall not take into account the improvement of the professional involved.

(E) Weights for the performance categories

(i) In general

Under the methodology developed under subparagraph (A), subject to subparagraph

(F)(i) and clause (ii), the composite performance score shall be determined as follows:

(I) Quality

(aa) In general

Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

(bb) First 5 years

For each of the first through fifth years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

(II) Resource use

(aa) In general

Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(bb) First 5 years

For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period.

(III) Clinical practice improvement activities

Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) Meaningful use of certified EHR technology

Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) Authority to adjust percentages in case of high EHR meaningful use adoption

In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (*o*)(5)) who are meaningful EHR users (as determined under subsection (*o*)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(F) Certain flexibility for weighting performance categories, measures, and activities

Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

(G) Resource use

Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(H) Inclusion of quality measure data from other payers

In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

(I) Use of voluntary virtual groups for certain assessment purposes

(i) In general

In the case of MIPS eligible professionals electing to be a virtual group under clause

(ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

(ii) Election of practices to be a virtual group

The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) Requirements

The requirements for the process under clause (ii) shall—

(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

(III) provide that a virtual group be a combination of tax identification numbers;

(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

(V) include such other requirements as the Secretary determines appropriate.

(6) MIPS payments

(A) MIPS adjustment factor

Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

(iv) in a manner such that—

(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

(B) Applicable percent defined

For purposes of this paragraph, the term ''applicable percent'' means—

(i) for 2019, 4 percent;

(ii) for 2020, 5 percent;

(iii) for 2021, 7 percent; and

(iv) for 2022 and subsequent years, 9 percent.

(C) Additional MIPS adjustment factors for exceptional performance

For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

(D) Establishment of performance thresholds

(i) Performance threshold

For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Subject to clauses (iii) and (iv), such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

(ii) Additional performance threshold for exceptional performance

In addition to the performance threshold under clause (i), for each year of the MIPS (beginning with 2019 and ending with 2024), the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, subject to clause (iii), the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

(iii) Special rule for initial 5 years

With respect to each of the first five years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C). Each such performance threshold shall—

(I) be based on a period prior to such performance periods; and

(II) take into account—

(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

(bb) other factors determined appropriate by the Secretary.

(iv) Additional special rule for third, fourth and fifth years of MIPS

For purposes of determining MIPS adjustment factors under subparagraph (A), in addition to the requirements specified in clause (iii), the Secretary shall increase the performance threshold with respect to each of the third, fourth, and fifth years to which the MIPS applies to ensure a gradual and incremental transition to the performance threshold described in clause (i) (as estimated by the Secretary) with respect to the sixth year to which the MIPS applies.

(E) Application of MIPS adjustment factors

In the case of covered professional services (as defined in subsection (k)(3)(A)) furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such covered professional services and MIPS eligible professional for such year, shall be multiplied by—

(i) 1, plus

(ii) the sum of—

(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C) divided by 100.

(F) Aggregate application of MIPS adjustment factors

(i) Application of scaling factor

(I) In general

With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall in-

crease or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

(II) Scaling factor limit

In no case may the scaling factor applied under this clause exceed 3.0.

(ii) Budget neutrality requirement

(I) In general

Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

(II) Aggregate increases

The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

(III) Aggregate decreases

The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

(iii) Exceptions

(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) and the additional adjustment factors under clause (iv) shall not apply for such year.

(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

(iv) Additional incentive payment adjustments

(I) In general

Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

(II) Limitation on additional incentive payment adjustments

The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

(7) Announcement of result of adjustments

Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for covered professional services (as defined in subsection (k)(3)(A)) furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

(8) No effect in subsequent years

The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

(9) Public reporting

(A) In general

The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

(ii) The names of eligible professionals in eligible alternative payment models[11] (as defined in section 1395*l*(z)(3)(D) of this title) and, to the extent feasible, the names of such eligible alternative pay-

[11] So in original. Section 1395*l*(z)(3)(D) of this title defines the term ''eligible alternative payment entity''.

ment models and performance of such models.

(B) Disclosure

The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(C) Opportunity to review and submit corrections

The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

(D) Aggregate information

The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

(10) Consultation

The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

(11) Technical assistance to small practices and practices in health professional shortage areas

(A) In general

The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 300jj–32(c) of this title), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in[7] section 254e(a)(1)(A) of this title), and medically underserved areas, and practices with low composite scores) with respect to—

(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1395*l*(z)(3)(C) of this title.

(B) Funding for technical assistance

For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title to the Centers for Medicare & Medicaid Services Program Management Account of $20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(12) Feedback and information to improve performance

(A) Performance feedback

(i) In general

Beginning July 1, 2017, the Secretary—

(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

(ii) Mechanisms

The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as[12] described in subsection (m)(3)(E)).

(iii) Use of data

For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

(iv) Disclosure exemption

Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5.

(v) Receipt of information

The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

[12] So in original. Probably should be preceded by an opening parenthesis.

(B) Additional information

(i) In general

Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this subchapter that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1395jjj of this title.

(ii) Type of information

For purposes of clause (i), the information described in this clause,[5] is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this subchapter and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

(13) Review

(A) Targeted review

The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

(B) Limitation

Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise of the following:

(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

(r) Collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement

(1) In general

In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1395*l*(z) of this title, the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

(2) Development of care episode and patient condition groups and classification codes

(A) In general

In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) Public availability of existing efforts to design an episode grouper

Not later than 180 days after April 16, 2015, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

(C) Stakeholder input

The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

(i) care episode groups; and
(ii) patient condition groups.

(D) Development of proposed classification codes

(i) In general

Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

(I) establish care episode groups and patient condition groups, which account for a target of an estimated ½ of expenditures under parts A and B (with such target increasing over time as appropriate); and

(II) assign codes to such groups.

(ii) Care episode groups

In establishing the care episode groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished; and

(II) other factors determined appropriate by the Secretary.

(iii) Patient condition groups

In establishing the patient condition groups under clause (i), the Secretary shall take into account—

(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

(II) other factors determined appropriate by the Secretary, such as eligibility status under this subchapter (including eligibility under section 426(a) of this title, section 426(b) of this title, or section 426–1 of this title, and dual eligibility under this subchapter and subchapter XIX).

(E) Draft care episode and patient condition groups and classification codes

Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

(F) Solicitation of input

The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

(G) Operational list of care episode and patient condition groups and codes

Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

(H) Subsequent revisions

Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(I) Information

The Secretary shall, not later than December 31st of each year (beginning with 2018), post on the Internet website of the Centers for Medicare & Medicaid Services information on resource use measures in use under subsection (q), resource use measures under development and the time-frame for such development, potential future resource use measure topics, a description of stakeholder engagement, and the percent of expenditures under part A and this part that are covered by resource use measures.

(3) Attribution of patients to physicians or practitioners

(A) In general

In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

(B) Development of patient relationship categories and codes

The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes

may reflect combinations of such categories), such as a physician or applicable practitioner who—

(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

(v) furnishes items and services only as ordered by another physician or practitioner.

(C) Draft list of patient relationship categories and codes

Not later than one year after April 16, 2015, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

(D) Stakeholder input

The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(E) Operational list of patient relationship categories and codes

Not later than 240 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

(F) Subsequent revisions

Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

(4) Reporting of information for resource use measurement

Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

(A) applicable codes established under paragraphs (2) and (3); and

(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

(5) Methodology for resource use analysis

(A) In general

In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate—

(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

(B) Analysis of patients of physicians and practitioners

In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

(ii) use the claims data experience of such patients by care episode codes—

(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

(C) Measurement of resource use

In measuring such resource use, the Secretary—

(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

(ii) may, as determined appropriate, use other measures of allowed charges (such as

subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

(D) Stakeholder input

The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

(6) Implementation

To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

(7) Limitation

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

(A) care episode and patient condition groups and codes established under paragraph (2);

(B) patient relationship categories and codes established under paragraph (3); and

(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

(8) Administration

Chapter 35 of title 44 shall not apply to this section.

(9) Definitions

In this subsection:

(A) Physician

The term ''physician'' has the meaning given such term in section 1395x(r)(1) of this title.

(B) Applicable practitioner

The term ''applicable practitioner'' means—

(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1395x(aa)(5) of this title), and a certified registered nurse anesthetist (as defined in section 1395x(bb)(2) of this title); and

(ii) beginning January 1, 2019, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

(10) Clarification

The provisions of sections 1395aaa(b)(7) of this title and 1395aaa–1 of this title shall not apply to this subsection.

(s) Priorities and funding for measure development

(1) Plan identifying measure development priorities and timelines

(A) Draft measure development plan

Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

(i) address how measures used by private payers and integrated delivery systems could be incorporated under subchapter XVIII;

(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

(B) Quality domains

For purposes of this subsection, the term ''quality domains'' means at least the following domains:

(i) Clinical care.

(ii) Safety.

(iii) Care coordination.

(iv) Patient and caregiver experience.

(v) Population health and prevention.

(C) Consideration

In developing the draft plan under this paragraph, the Secretary shall consider—

(i) gap analyses conducted by the entity with a contract under section 1395aaa(a) of this title or other contractors or entities;

(ii) whether measures are applicable across health care settings;

(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

(iv) the quality domains applied under this subsection.

(D) Priorities

In developing the draft plan under this paragraph, the Secretary shall give priority to the following types of measures:

(i) Outcome measures, including patient reported outcome and functional status measures.

(ii) Patient experience measures.

(iii) Care coordination measures.

(iv) Measures of appropriate use of services, including measures of over use.

(E) Stakeholder input

The Secretary shall accept through March 1, 2016, comments on the draft plan posted

under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

(F) Final measure development plan

Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

(2) Contracts and other arrangements for quality measure development

(A) In general

The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

(B) Prioritization

(i) In general

In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

(ii) Consideration

In selecting measures for development under this subsection, the Secretary shall consider—

(I) whether such measures would be electronically specified; and

(II) clinical practice guidelines to the extent that such guidelines exist.

(3) Annual report by the Secretary

(A) In general

Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

(B) Requirements

Each report submitted pursuant to subparagraph (A) shall include the following:

(i) A description of the Secretary's efforts to implement this paragraph.

(ii) With respect to the measures developed during the previous year—

(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

(II) the name of each measure developed;

(III) the name of the developer and steward of each measure;

(IV) with respect to each type of measure, an estimate of the total amount expended under this subchapter to develop all measures of such type; and

(V) whether the measure would be electronically specified.

(iii) With respect to measures in development at the time of the report—

(I) the information described in clause (ii), if available; and

(II) a timeline for completion of the development of such measures.

(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

(v) Other information the Secretary determines to be appropriate.

(4) Stakeholder input

With respect to paragraph (1), the Secretary shall seek stakeholder input with respect to—

(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

(B) prioritizing quality measure development to address such gaps; and

(C) other areas related to quality measure development determined appropriate by the Secretary.

(5) Definition of applicable provisions

In this subsection, the term ''applicable provisions'' means the following provisions:

(A) Subsection (q)(2)(B)(i).

(B) section[13] 1395*l*(z)(3)(D) of this title.

(6) Funding

For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2015 through 2019. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2022.

(7) Administration

Chapter 35 of title 44 shall not apply to the collection of information for the development of quality measures.

(t) Supporting physicians and other professionals in adjusting to Medicare payment changes during 2021 and 2022

(1) In general

In order to support physicians and other professionals in adjusting to changes in payment for physicians' services during 2021 and 2022, the Secretary shall increase fee schedules under subsection (b) that establish payment amounts for—

(A) such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent; and

(B) such services furnished on or after January 1, 2022, and before January 1, 2023, by 3.0 percent.

[13] So in original. Probably should be ''Section''.

(2) Implementation

(A) Administration

Notwithstanding any other provision of law, the Secretary may implement this subsection by program instruction or otherwise.

(B) Limitation

There shall be no administrative or judicial review under section 1395ff of this title, 1395*oo* of this title[6] or otherwise of the fee schedules that establish payment amounts calculated pursuant to this subsection.

(C) Application only for 2021 and 2022

The increase in fee schedules that establish payment amounts under this subsection for services furnished in 2021 or 2022 shall not be taken into account in determining such fee schedules that establish payment amounts for services furnished in years after 2021 or 2022, respectively.

(3) Funding

For purposes of increasing the fee schedules that establish payment amounts pursuant to this subsection—

(A) there shall be transferred from the General Fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, $3,000,000,000, to remain available until expended; and

(B) in the event the Secretary determines additional amounts are necessary, such amounts shall be available from the Federal Supplementary Medical Insurance Trust Fund.

(Aug. 14, 1935, ch. 531, title XVIII, §1848, as added Pub. L. 101–239, title VI, §6102(a), Dec. 19, 1989, 103 Stat. 2169; amended Pub. L. 101–508, title IV, §§4102(b), (g)(2), 4104(b)(2), 4105(a)(3), (c), 4106(b)(1), 4107(a)(1), 4109(a), 4116, 4118(b)–(f)(1), (k), Nov. 5, 1990, 104 Stat. 1388–56, 1388–57, 1388–59 to 1388–63, 1388–65, 1388–67, 1388–68, 1388–71; Pub. L. 103–66, title XIII, §§13511(a), 13512–13514(c), 13515(a)(1), (c), 13516(a)(1), 13517(a), 13518(a), Aug. 10, 1993, 107 Stat. 580–583, 585, 586; Pub. L. 103–432, title I, §§121(b)(1), (2), 122(a), (b), 123(a), (d), 126(b)(6), (g)(2)(B), (5)–(7), (10)(A), Oct. 31, 1994, 108 Stat. 4409, 4410, 4412, 4415, 4416; Pub. L. 105–33, title IV, §§4022(b)(2)(B), (C), 4102(d), 4103(d), 4104(d), 4105(a)(2), 4106(b), 4501, 4502(a)(1), (b), 4503, 4504(a), 4505(a), (b), (e), (f)(1), 4644(d), 4714(b)(2), Aug. 5, 1997, 111 Stat. 354, 355, 361, 362, 365, 366, 368, 432–437, 488, 510; Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(a)(1), (2)(A), (3)(A), (b), title III, §321(k)(5)], Nov. 29, 1999, 113 Stat. 1536, 1501A–345 to 1501A–348, 1501A–366; Pub. L. 106–554, §1(a)(6) [title I, §104(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–469; Pub. L. 108–7, div. N, title IV, §402(a), Feb. 20, 2003, 117 Stat. 548; Pub. L. 108–173, title III, §303(a)(1), (g)(2), title IV, §412, title VI, §§601(a)(1), (2), (b)(1), 602, 611(c), title VII, §736(b)(10), Dec. 8, 2003, 117 Stat. 2233, 2253, 2274, 2300, 2301, 2304, 2356; Pub. L. 109–171, title V, §§5102, 5104(a), 5112(c), Feb. 8, 2006, 120 Stat. 39, 40, 44; Pub. L. 109–432, div. B, title I, §§101(a), (b), (d), 102, Dec. 20, 2006, 120 Stat. 2975, 2980, 2981; Pub. L. 110–90, §6, Sept. 29, 2007, 121 Stat. 985; Pub. L. 110–161, div. G, title II, §225(c)(2), title V, §524, Dec. 26, 2007, 121 Stat. 2190, 2212; Pub. L. 110–173, title I, §§101(a)(1), (2)(A), (b)(1), 103, Dec. 29, 2007, 121 Stat. 2493–2495; Pub. L. 110–252, title VII, §7002(c), June 30, 2008, 122 Stat. 2395; Pub. L. 110–275, title I, §§131(a)(1), (3)(C), (b)(1)–(4)(A), (5), (c)(1), 132(a), (b), 133(b), 134, 139(a), 144(a)(2), 152(b)(1)(C), July 15, 2008, 122 Stat. 2520–2522, 2525–2527, 2529, 2532, 2541, 2546, 2552; Pub. L. 111–5, div. B, title IV, §4101(a), (b), (f), Feb. 17, 2009, 123 Stat. 467, 472, 476; Pub. L. 111–118, div. B, §1011(a), Dec. 19, 2009, 123 Stat. 3473; Pub. L. 111–144, §5, Mar. 2, 2010, 124 Stat. 46; Pub. L. 111–148, title III, §§3002(a)–(c)(1), (d)–(f), 3003(a), 3007, 3101, 3102, 3111(a)(1), 3134(a), 3135(a), (b), title IV, §4103(c)(2), title V, §5501(c), title X, §§10310, 10324(c), 10327(a), 10501(h), Mar. 23, 2010, 124 Stat. 363–366, 373, 415, 416, 421, 434, 436, 437, 556, 654, 942, 960, 962, 997; Pub. L. 111–152, title I, §§1107, 1108, Mar. 30, 2010, 124 Stat. 1050; Pub. L. 111–157, §§4, 5(a)(1), Apr. 15, 2010, 124 Stat. 1117; Pub. L. 111–192, title I, §101(a), June 25, 2010, 124 Stat. 1280; Pub. L. 111–286, §§2, 3, Nov. 30, 2010, 124 Stat. 3056; Pub. L. 111–309, title I, §§101, 103, Dec. 15, 2010, 124 Stat. 3285, 3287; Pub. L. 112–78, title III, §§301, 303, 309, Dec. 23, 2011, 125 Stat. 1283, 1284, 1286; Pub. L. 112–96, title III, §§3003(a), 3004(a), Feb. 22, 2012, 126 Stat. 186, 187; Pub. L. 112–240, title VI, §§601(a), (b)(1), 602, 633(a), 635, Jan. 2, 2013, 126 Stat. 2345, 2347, 2355, 2356; Pub. L. 113–67, div. B, title I, §§1101, 1102, Dec. 26, 2013, 127 Stat. 1196; Pub. L. 113–93, title I, §§101, 102, title II, §§218(a)(2)(B), 220(a)–(f), (h), Apr. 1, 2014, 128 Stat. 1041, 1064, 1070–1074; Pub. L. 113–295, div. B, title II, §202, Dec. 19, 2014, 128 Stat. 4065; Pub. L. 114–10, title I, §§101(a)(1), (2), (b), (c)(1), (d), (f), 102, 103(a), 106(b)(2)(A), title II, §201, title V, §523, Apr. 16, 2015, 129 Stat. 89, 91, 92, 115, 123–131, 139, 143, 177; Pub. L. 114–113, div. O, title V, §502(a)(1)–(2)(B), Dec. 18, 2015, 129 Stat. 3018, 3019; Pub. L. 114–115, §§3(a), 4(a), Dec. 28, 2015, 129 Stat. 3132, 3133; Pub. L. 114–255, div. A, title IV, §4002(b)(1), div. C, title XVI, §16003, Dec. 13, 2016, 130 Stat. 1161, 1326; Pub. L. 115–123, div. E, title II, §50201, title IV, §50413, title X, §§51003(a), 51009, title XII, §53106, Feb. 9, 2018, 132 Stat. 176, 221, 293, 297, 303; Pub. L. 116–94, div. N, title I, §101, Dec. 20, 2019, 133 Stat. 3096; Pub. L. 116–136, div. A, title III, §3801, Mar. 27, 2020, 134 Stat. 427; Pub. L. 116–159, div. C, title II, §2201, Oct. 1, 2020, 134 Stat. 730; Pub. L. 116–215, div. B, title I, §1101, Dec. 11, 2020, 134 Stat. 1042; Pub. L. 116–260, div. N, title I, §101(a), (b), div. CC, title I, §§101, 114(b), 119(c), Dec. 27, 2020, 134 Stat. 1949, 1950, 2940, 2948, 2953; Pub. L. 117–71, §3(a), Dec. 10, 2021, 135 Stat. 1507.)

Editorial Notes

REFERENCES IN TEXT

Section 13515(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsecs. (a)(2)(B)(ii)(I), (c)(2)(A)(i), and (i)(1)(B), is section 13515(b) of Pub. L. 103–66, which is set out as a note under section 1395u of this title.

Section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (a)(2)(D)(ii), (iii), is section 6105(b) of Pub. L. 101–239, which is set out as a note under section 1395m of this title.

Section 4048(b) of the Omnibus Budget Reconciliation Act of 1987, referred to in subsec. (b)(2)(B), is section 4048(b) of Pub. L. 100–203, which is set out as a note under section 1395u of this title.

Section 13514(a) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (c)(2)(F), is sec-

tion 13514(a) of Pub. L. 103–66, which amended subsec. (b)(3) of this section. See 1993 Amendment note below.

Section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, referred to in subsec. (c)(2)(H)(i), (I)(ii)(I), is section 1000(a)(6) [title II, § 212] of Pub. L. 106–113, which is set out as a note under this section.

The Balanced Budget Act of 1997, referred to in subsec. (d)(1)(C), is Pub. L. 105–33, Aug. 5, 1997, 111 Stat. 251. Chapter 1 of subtitle F of title IV of the Act is chapter 1 (§§ 4501–4513) of subtitle F of title IV of Pub. L. 105–33, which amended this section and sections 1395a, 1395k, 1395*l*, 1395u, 1395x, 1395y, 1395cc, and 1395yy of this title and enacted provisions set out as notes under this section and sections 1395a, 1395k, 1395*l*, 1395x, and 1395ww of this title. For complete classification of this Act to the Code, see Tables.

Section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008, referred to in subsec. (*l*)(2)(A)(ii)(I), (II), are sections 225(c)(1) of title II and 524 of title V of div. G of Pub. L. 110–161, Dec. 26, 2007, 121 Stat. 2190, 2212. Section 225(c)(1) is not classified to the Code and section 524 amended this section.

Section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, referred to in subsec. (q)(1)(G)(i), is section 2(d) of Pub. L. 113–185, which is set out as a note under section 1395*lll* of this title.

CODIFICATION

The text of section 101(c) of Pub. L. 109–432, div. B, title I, Dec. 20, 2006, 120 Stat. 2977, as amended by Pub. L. 110–173, title I, § 101(b)(2), Dec. 29, 2007, 121 Stat. 2494, which was formerly set out as a note under this section, was transferred to subsec. (m) of this section and amended by Pub. L. 110–275.

AMENDMENTS

2021—Subsec. (c)(2)(B)(iv)(V). Pub. L. 117–71, § 3(a)(1), substituted ''2021 or 2022'' for ''2021''.

Subsec. (t). Pub. L. 117–71, § 3(a)(2)(A), substituted ''2021 and 2022'' for ''2021'' in heading.

Subsec. (t)(1). Pub. L. 117–71, § 3(a)(2)(B), substituted ''during 2021 and 2022'' for ''during 2021'' and ''payment amounts for—'' and subpars. (A) and (B) for ''payment amounts for such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent.''

Subsec. (t)(2)(C). Pub. L. 117–71, § 3(a)(2)(C), substituted ''2021 and 2022'' for ''2021'' in heading and, in text, inserted ''for services furnished in 2021 or 2022'' after ''under this subsection'' and ''or 2022, respectively'' before period at end.

2020—Subsec. (c)(2)(B)(iv)(V). Pub. L. 116–260, § 101(b), added subcl. (V).

Subsec. (e)(1)(E). Pub. L. 116–260 substituted ''January 1, 2024'' for ''December 19, 2020''.

Pub. L. 116–215 substituted ''December 19, 2020'' for ''December 12, 2020''.

Pub. L. 116–159 substituted ''December 12, 2020'' for ''December 1, 2020''.

Pub. L. 116–136 substituted ''December 1, 2020'' for ''May 23, 2020''.

Subsec. (q)(1)(C)(iii)(II). Pub. L. 116–260, § 114(b)(1), substituted ''each of 2021 through 2024'' for ''2021 and 2022'' in introductory provisions.

Subsec. (q)(1)(C)(iii)(III). Pub. L. 116–260, § 114(b)(2), substituted ''2025'' for ''2023'' in introductory provisions.

Subsec. (q)(2)(B)(iii)(IV). Pub. L. 116–260, § 119(c), inserted at end ''This subcategory shall include as an activity, for performance periods beginning on or after January 1, 2022, use of a real-time benefit tool as described in section 1395w–104(*o*) of this title. The Secretary may establish this activity as a standalone or as a component of another activity.''

Subsec. (t). Pub. L. 116–260, § 101(a), added subsec. (t).

2019—Subsec. (e)(1)(E). Pub. L. 116–94 substituted ''May 23, 2020'' for ''January 1, 2020''.

2018—Subsec. (b)(11). Pub. L. 115–123, § 51009(1), substituted ''2017, 2018, and 2019'' for ''2017 and 2018''.

Subsec. (c)(2)(K)(iv). Pub. L. 115–123, § 51009(2), substituted ''2017, 2018, and 2019'' for ''2017 and 2018''.

Subsec. (d)(18). Pub. L. 115–123, § 53106, substituted ''paragraph (1)(C)—'' for ''paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.'' and added subpars. (A) and (B).

Subsec. (e)(1)(E). Pub. L. 115–123, § 50201, substituted ''January 1, 2020'' for ''January 1, 2018''.

Subsec. (*o*)(2)(A). Pub. L. 115–123, § 50413, struck out ''by requiring more stringent measures of meaningful use selected under this paragraph'' after ''health care quality over time'' in concluding provisions.

Subsec. (q)(1)(B). Pub. L. 115–123, § 51003(a)(1)(A)(i), substituted ''covered professional services (as defined in subsection (k)(3)(A))'' for ''items and services''.

Subsec. (q)(1)(C)(iv)(I). Pub. L. 115–123, § 51003(a)(1)(A)(ii)(I), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: ''The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.''

Subsec. (q)(1)(C)(iv)(II). Pub. L. 115–123, § 51003(a)(1)(A)(ii)(II), substituted ''covered professional services (as defined in subsection (k)(3)(A))'' for ''items and services''.

Subsec. (q)(1)(C)(iv)(III). Pub. L. 115–123, § 51003(a)(1)(A)(ii)(III), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: ''The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.''

Subsec. (q)(5)(D)(i)(I). Pub. L. 115–123, § 51003(a)(1)(B)(i), inserted ''subject to clause (iii),'' after ''clauses (i) and (ii) of paragraph (2)(A),''.

Subsec. (q)(5)(D)(iii). Pub. L. 115–123, § 51003(a)(1)(B)(ii), added cl. (iii).

Subsec. (q)(5)(E)(i)(I)(bb). Pub. L. 115–123, § 51003(a)(1)(C)(i), substituted ''First 5 years'' for ''First 2 years'' in heading and ''each of the first through fifth years'' for ''the first and second years'' in text.

Subsec. (q)(5)(E)(i)(II)(bb). Pub. L. 115–123, § 51003(a)(1)(C)(ii), substituted ''5 years'' for ''2 years'' in heading and ''For each of the second, third, fourth, and fifth years for which the MIPS applies to payments, not less than 10 percent and not more than 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). Nothing in the previous sentence shall be construed, with respect to a performance period for a year described in the previous sentence, as preventing the Secretary from basing 30 percent of such score for such year with respect to the category described in such clause (ii), if the Secretary determines, based on information posted under subsection (r)(2)(I) that sufficient resource use measures are ready for adoption for use under the performance category under paragraph (2)(A)(ii) for such performance period.'' for ''For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).'' in text.

Subsec. (q)(6)(D)(i). Pub. L. 115–123, § 51003(a)(1)(D)(i), substituted ''Subject to clauses (iii) and (iv), such performance threshold'' for ''Such performance threshold''.

Subsec. (q)(6)(D)(ii). Pub. L. 115–123, § 51003(a)(1)(D)(ii), in introductory provisions, inserted ''(beginning with 2019 and ending with 2024)'' after ''for each year of the MIPS'' and ''subject to clause (iii),'' after ''For each such year,''.

Subsec. (q)(6)(D)(iii). Pub. L. 115–123, § 51003(a)(1)(D)(iii), substituted ''5'' for ''2'' in heading and ''five years'' for ''two years'' in introductory provisions.

Subsec. (q)(6)(D)(iv). Pub. L. 115–123, § 51003(a)(1)(D)(iv), added cl. (iv).

Subsec. (q)(6)(E). Pub. L. 115–123, § 51003(a)(1)(E), in introductory provisions, substituted ''In the case of covered professional services (as defined in subsection (k)(3)(A))'' for ''In the case of items and services'' and ''under this part with respect to such covered professional services'' for ''under this part with respect to such items and services''.

Subsec. (q)(7). Pub. L. 115–123, § 51003(a)(1)(F), substituted ''covered professional services (as defined in subsection (k)(3)(A))'' for ''items and services''.

Subsec. (r)(2)(I). Pub. L. 115–123, § 51003(a)(2), added subpar. (I).

Subsec. (s)(5)(B). Pub. L. 115–123, § 51003(a)(3), which directed amendment of subpar. (B) by substituting ''section 1395*l*(z)(3)(D)'' for ''section 1395*l*(z)(2)(C)'', was executed by making the substitution for ''Section 1395*l*(z)(2)(C)'' to reflect the probable intent of Congress.

2016—Subsec. (a)(7)(B). Pub. L. 114–255, § 4002(b)(1)(A), inserted after first sentence ''The Secretary shall exempt an eligible professional from the application of the payment adjustment under subparagraph (A) with respect to a year, subject to annual renewal, if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by such professional has been decertified under a program kept or recognized pursuant to section 300jj–11(c)(5) of this title.''

Subsec. (a)(7)(D). Pub. L. 114–255, § 16003, substituted ''hospital-based and ambulatory surgical center-based eligible professionals'' for ''hospital-based eligible professionals'' in heading, designated existing provisions as cl. (i), inserted cl. (i) heading, and added cls. (ii) to (iv).

Subsec. (*o*)(2)(D). Pub. L. 114–255, § 4002(b)(1)(B), inserted at end ''The provisions of subparagraphs (B) and (D) of subsection (a)(7), shall apply to assessments of MIPS eligible professionals under subsection (q) with respect to the performance category described in subsection (q)(2)(A)(iv) in an appropriate manner which may be similar to the manner in which such provisions apply with respect to payment adjustments made under subsection (a)(7)(A).''

2015—Subsec. (a)(7)(A)(i). Pub. L. 114–10, § 101(b)(1)(A)(i), substituted ''each of 2015 through 2018'' for ''2015 or any subsequent payment year''.

Subsec. (a)(7)(A)(ii)(III). Pub. L. 114–10, § 101(b)(1)(A)(ii), substituted ''2018'' for ''each subsequent year''.

Subsec. (a)(7)(A)(iii). Pub. L. 114–10, § 101(b)(1)(A)(iii), struck out ''and subsequent years'' after ''for 2018'' in heading and ''and each subsequent year'' after ''For 2018'' and '', but in no case shall the applicable percent be less than 95 percent'' after ''in the preceding year'' in text.

Subsec. (a)(7)(B). Pub. L. 114–115, § 4(a), inserted ''(and, with respect to the payment adjustment under subparagraph (A) for 2017, for categories of eligible professionals, as established by the Secretary and posted on the Internet website of the Centers for Medicare & Medicaid Services prior to December 15, 2015, an application for which must be submitted to the Secretary by not later than March 15, 2016)'' after ''case-by-case basis''.

Subsec. (a)(8)(A)(i). Pub. L. 114–10, § 101(b)(2)(A)(i), substituted ''each of 2015 through 2018'' for ''2015 or any subsequent year''.

Subsec. (a)(8)(A)(ii)(II). Pub. L. 114–10, § 101(b)(2)(A)(ii), substituted '', 2017, and 2018'' for ''and each subsequent year''.

Subsec. (a)(9). Pub. L. 114–10, § 523(b), added par. (9).

Subsec. (b)(8). Pub. L. 114–10, § 103(a), added par. (8).

Subsec. (b)(9). Pub. L. 114–113, § 502(a)(1)(A), added par. (9).

Subsec. (b)(10). Pub. L. 114–113, § 502(a)(2)(A), added par. (10).

Subsec. (b)(11). Pub. L. 114–115, § 3(a)(1), added par. (11).

Subsec. (c)(2)(B)(v)(X). Pub. L. 114–113, § 502(a)(1)(B), added subcl. (X).

Subsec. (c)(2)(B)(v)(XI). Pub. L. 114–113, § 502(a)(2)(B), added subcl. (XI).

Subsec. (c)(2)(K)(iv). Pub. L. 114–115, § 3(a)(2), added cl. (iv).

Subsec. (c)(8). Pub. L. 114–10, § 523(a), added par. (8).

Subsec. (d)(1)(A). Pub. L. 114–10, § 101(a)(1)(A)(i), (2)(A), inserted ''and ending with 2025'' after ''beginning with 2001'', ''or a subsequent paragraph'' after ''paragraph (4)'', and ''There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1395*l*(z)(2) of this title) (referred to in this subsection as the 'qualifying APM conversion factor') and the other for other items and services (referred to in this subsection as the 'nonqualifying APM conversion factor'), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.'' at end.

Subsec. (d)(1)(D). Pub. L. 114–10, § 101(a)(2)(B), inserted ''(or, beginning with 2026, applicable conversion factor)'' after ''single conversion factor''.

Subsec. (d)(4). Pub. L. 114–10, § 101(a)(1)(A)(ii)(I), inserted ''and ending with 2014'' after ''years beginning with 2001'' in heading.

Subsec. (d)(4)(A). Pub. L. 114–10, § 101(a)(1)(A)(ii)(II), inserted ''and ending with 2014'' after ''a year beginning with 2001'' in introductory provisions.

Subsec. (d)(16) to (20). Pub. L. 114–10, § 101(a)(2)(C), added pars. (16) to (20) and struck out former par. (16) which related to update for January through March of 2015.

Subsec. (e)(1)(E). Pub. L. 114–10, § 201, substituted ''January 1, 2018'' for ''April 1, 2015''.

Subsec. (f)(1)(B). Pub. L. 114–10, § 101(a)(1)(B)(i), inserted ''through 2014'' after ''of each succeeding year''.

Subsec. (f)(2). Pub. L. 114–10, § 101(a)(1)(B)(ii), inserted ''and ending with 2014'' after ''beginning with 2000'' in introductory provisions.

Subsec. (k)(9). Pub. L. 114–10, § 101(b)(2)(B)(i), added par. (9).

Subsec. (m)(3)(C)(ii). Pub. L. 114–10, § 101(d)(1)(A), inserted ''and, for 2016 and subsequent years, may provide'' after ''shall provide''.

Subsec. (m)(3)(D). Pub. L. 114–10, § 101(d)(1)(B), inserted ''and, for 2016 and subsequent years, subparagraph (A) or (C)'' after ''subparagraph (A)''.

Subsec. (m)(5)(F). Pub. L. 114–10, § 101(d)(2), substituted ''through reporting periods occurring in 2015'' for ''and subsequent years'' and inserted ''and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish'' after ''shall establish''.

Subsec. (m)(7) to (9). Pub. L. 114–10, § 101(b)(2)(B)(ii), redesignated par. (7) relating to additional incentive payment as (8) and added par. (9).

Subsec. (n)(11). Pub. L. 114–10, § 101(d)(3), added par. (11).

Subsec. (*o*)(2)(A). Pub. L. 114–10, § 101(b)(1)(B)(i), in introductory provisions, substituted ''An'' for ''For purposes of paragraph (1), an'' and inserted '', or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year'' after ''under such subsection for a year''.

Subsec. (*o*)(2)(A)(ii). Pub. L. 114–10, § 106(b)(2)(A), inserted '', and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology'' before period at end.

Subsec. (*o*)(2)(A)(iii). Pub. L. 114–10, § 101(d)(4), inserted ''and subsection (q)(5)(B)(ii)(II)'' after ''Subject to subparagraph (B)(ii)''.

Subsec. (*o*)(2)(D). Pub. L. 114–10, § 101(b)(1)(B)(ii), added subpar. (D).

Subsec. (p)(2)(C). Pub. L. 114–10, § 101(b)(3)(B)(i), added subpar. (C).

Subsec. (p)(3). Pub. L. 114–10, § 101(b)(3)(B)(ii), inserted at end ''With respect to 2019 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).''

Subsec. (p)(4)(B)(iii). Pub. L. 114–10, § 101(b)(3)(A), amended cl. (iii) generally. Prior to amendment, text read as follows: ''The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

''(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

''(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.''

Subsec. (q). Pub. L. 114–10, § 101(c)(1), added subsec. (q).

Subsec. (r). Pub. L. 114–10, § 101(f), added subsec. (r).

Subsec. (s). Pub. L. 114–10, § 102, added subsec. (s).

2014—Subsec. (c)(2)(B)(ii)(I). Pub. L. 113–93, § 220(e)(2)(A), substituted ''subclause (II) and paragraph (7)'' for ''subclause (II)''.

Subsec. (c)(2)(B)(v)(VIII). Pub. L. 113–295, § 202(1)(A), substituted ''2016'' for ''2017'' in subcl. (VIII) relating to reductions for misvalued services if target not met.

Pub. L. 113–93, § 220(d)(2), added subcl. (VIII) relating to reductions for misvalued services if target not met.

Pub. L. 113–93, § 218(a)(2)(B), added subcl. (VIII) relating to reduced expenditures attributable to application of quality incentives for computed tomography.

Subsec. (c)(2)(B)(v)(IX). Pub. L. 113–295, § 202(1)(B), redesignated subcl. (VIII) relating to reductions for misvalued services if target not met as (IX).

Subsec. (c)(2)(C)(i). Pub. L. 113–93, § 220(f)(1), substituted ''the service or group of services'' for ''the service'' in two places.

Subsec. (c)(2)(C)(ii). Pub. L. 113–93, § 220(f)(2), inserted ''or group of services'' after ''furnishing the service'' the first time appearing in concluding provisions.

Subsec. (c)(2)(C)(iii). Pub. L. 113–93, § 220(f)(1), substituted ''the service or group of services'' for ''the service'' wherever appearing.

Subsec. (c)(2)(K)(ii). Pub. L. 113–93, § 220(c), amended cl. (ii) generally. Prior to amendment, text read as follows: ''For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.''

Subsec. (c)(2)(K)(iii)(VI). Pub. L. 113–93, § 220(e)(2)(B), substituted ''provisions of subparagraph (B)(ii)(II) and paragraph (7)'' for ''provisions of subparagraph (B)(ii)(II)'' and ''under subparagraph (B)(ii)(I)'' for ''under subparagraph (B)(ii)(II)''.

Subsec. (c)(2)(M). Pub. L. 113–93, § 220(a)(1), added subpar. (M).

Subsec. (c)(2)(N). Pub. L. 113–93, § 220(b), added subpar. (N).

Subsec. (c)(2)(O). Pub. L. 113–295, § 202(2)(A), substituted ''2016 through 2018'' for ''2017 through 2020'' in introductory provisions.

Pub. L. 113–93, § 220(d)(1), added subpar. (O).

Subsec. (c)(2)(O)(iii). Pub. L. 113–295, § 202(2)(B), substituted ''2016'' for ''2017''.

Subsec. (c)(2)(O)(v). Pub. L. 113–295, § 202(2)(C), inserted ''(or, for 2016, 1.0 percent)'' after ''0.5 percent''.

Subsec. (c)(7). Pub. L. 113–295, § 202(3), substituted ''2016'' for ''2017''.

Pub. L. 113–93, § 220(e)(1), added par. (7).

Subsec. (d)(15). Pub. L. 113–93, § 101(1)(A), struck out ''January through March of'' before ''2014'' in heading.

Subsec. (d)(15)(A). Pub. L. 113–93, § 101(1)(B), struck out ''for the period beginning on January 1, 2014, and ending on March 31, 2014'' after ''2014''.

Subsec. (d)(15)(B). Pub. L. 113–93, § 101(1)(C), struck out ''remaining portion of 2014 and'' before ''subsequent years'' in heading and ''the period beginning on April 1, 2014, and ending on December 31, 2014, and for'' before ''2015'' in text.

Subsec. (d)(16). Pub. L. 113–93, § 101(2), added par. (16).

Subsec. (e)(1)(E). Pub. L. 113–93, § 102, substituted ''April 1, 2015'' for ''April 1, 2014''.

Subsec. (e)(6). Pub. L. 113–93, § 220(h)(1), added par. (6).

Subsec. (i)(1)(F). Pub. L. 113–93, § 220(a)(2), added subpar. (F).

Subsec. (j)(2). Pub. L. 113–93, § 220(h)(2), substituted ''Except as provided in subsection (e)(6)(D), the term'' for ''The term''.

2013—Subsec. (b)(4)(C). Pub. L. 112–240, § 635(1), substituted '', 2012, and 2013'' for ''and subsequent years'' and inserted at end ''With respect to fee schedules established for 2014 and subsequent years, in such methodology, the Secretary shall use a 90 percent utilization rate.''

Subsec. (b)(7). Pub. L. 112–240, § 633(a), substituted ''2011, and before April 1, 2013,'' for ''2011,'' and inserted at end ''In the case of such services furnished on or after April 1, 2013, and for which payment is made under such fee schedules, instead of the 25 percent multiple procedure payment reduction specified in such final rule, the reduction percentage shall be 50 percent.''

Subsec. (c)(2)(B)(v)(III). Pub. L. 112–240, § 635(2), substituted ''changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively, of'' for ''change in the utilization rate applicable to 2011, as described in''.

Subsec. (d)(14). Pub. L. 112–240, § 601(a), added par. (14).

Subsec. (d)(15). Pub. L. 113–67, § 1101, added par. (15).

Subsec. (e)(1)(E). Pub. L. 113–67, § 1102, substituted ''April 1, 2014'' for ''January 1, 2014''.

Pub. L. 112–240, § 602, substituted ''before January 1, 2014'' for ''before January 1, 2013''.

Subsec. (m)(3)(D) to (F). Pub. L. 112–240, § 601(b)(1), added subpars. (D) and (E) and redesignated former subpar. (D) as (F).

2012—Subsec. (d)(13). Pub. L. 112–96, § 3003(a)(1), substituted ''2012'' for ''first two months of 2012'' in heading.

Subsec. (d)(13)(A). Pub. L. 112–96, § 3003(a)(2), substituted ''2012'' for ''the period beginning on January 1, 2012, and ending on February 29, 2012''.

Subsec. (d)(13)(B). Pub. L. 112–96, § 3003(a)(3), (4), substituted ''2013'' for ''remaining portion of 2012'' in heading and ''for 2013'' for ''for the period beginning on March 1, 2012, and ending on December 31, 2012, and for 2013'' in text.

Subsec. (e)(1)(E). Pub. L. 112–96, § 3004(a), substituted ''before January 1, 2013'' for ''before March 1, 2012''.

2011—Subsec. (b)(4)(B), (6). Pub. L. 112–78, § 309(1), substituted '', 2011, and the first 2 months of 2012'' for ''and 2011'' wherever appearing.

Subsec. (c)(2)(B)(iv)(IV). Pub. L. 112–78, § 309(2), substituted '', 2011, or the first 2 months of 2012'' for ''or 2011''.

Subsec. (d)(13). Pub. L. 112–78, § 301, added par. (13).

Subsec. (e)(1)(E). Pub. L. 112–78, § 303, substituted ''before March 1, 2012'' for ''before January 1, 2012''.

2010—Subsec. (a)(8). Pub. L. 111–148, § 3002(b), added par. (8).

Subsec. (b)(1). Pub. L. 111–148, § 3007(1), inserted ''subject to subsection (p),'' after ''1998,'' in introductory provisions.

Subsec. (b)(4)(B). Pub. L. 111–152, § 1107(1)(A), substituted ''subparagraph (A)'' for ''this paragraph''.

Pub. L. 111–148, § 3135(a)(1)(A), substituted ''this paragraph'' for ''subparagraph (A)''.

Pub. L. 111–148, § 3111(a)(1)(A)(i), inserted '', and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))'' before the period.

Subsec. (b)(4)(C). Pub. L. 111–152, §1107(1)(B), amended subpar. (C) generally. Prior to amendment, text read as follows: ''Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1395m(e)(1)(B) of this title) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects—

''(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

''(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

''(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''

Pub. L. 111–148, §3135(a)(1)(B), added subpar. (C).

Subsec. (b)(4)(D). Pub. L. 111–148, §3135(b)(1), added subpar. (D).

Subsec. (b)(6). Pub. L. 111–148, §3111(a)(1)(A)(ii), added par. (6).

Subsec. (b)(7). Pub. L. 111–286, §3(a), added par. (7).

Subsec. (c)(2)(B)(iv)(IV). Pub. L. 111–148, §3111(a)(1)(B), added subcl. (IV).

Subsec. (c)(2)(B)(v)(III) to (V). Pub. L. 111–152, §1107(2), added subcl. (III) and struck out former subcls. (III) to (V), which read as follows:

''(III) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2010 THROUGH 2012.—Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

''(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2013.—Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

''(V) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2014 AND SUBSEQUENT YEARS.—Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent.''

Pub. L. 111–148, §3135(a)(2), added subcls. (III) to (V).

Subsec. (c)(2)(B)(v)(VI). Pub. L. 111–148, §3135(b)(2), added subcl. (VI).

Subsec. (c)(2)(B)(v)(VII). Pub. L. 111–286, §3(b), added subcl. (VII).

Subsec. (c)(2)(B)(vii). Pub. L. 111–148, §5501(c), which directed the addition of cl. (vii), was repealed by Pub. L. 111–148, §10501(h). As enacted, text read as follows: ''Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1395*l* of this title for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for 2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1395*l*(m) of this title by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 254e(a)(1)(A) of this title) as health professional shortage areas.''

Subsec. (c)(2)(K), (L). Pub. L. 111–148, §3134(a), added subpars. (K) and (L).

Subsec. (d)(10). Pub. L. 111–192, §101(a)(1), substituted ''January through May'' for ''portion'' in heading.

Pub. L. 111–148, §3101, which directed the addition of par. (10) relating to update for 2010, was repealed by Pub. L. 111–148, §10310. As enacted, text read as follows:

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.''

Subsec. (d)(10)(A). Pub. L. 111–157, §4(1), substituted ''May 31, 2010'' for ''March 31, 2010''.

Pub. L. 111–144, §5(1), substituted ''March 31, 2010'' for ''February 28, 2010''.

Subsec. (d)(10)(B). Pub. L. 111–157, §4(2), substituted ''June 1, 2010'' for ''April 1, 2010''.

Pub. L. 111–144, §5(2), substituted ''April 1, 2010'' for ''March 1, 2010''.

Subsec. (d)(11). Pub. L. 111–286, §2(1), substituted ''December'' for ''November'' in heading.

Pub. L. 111–192, §101(a)(2), added par. (11).

Subsec. (d)(11)(A). Pub. L. 111–286, §2(2), substituted ''December 31'' for ''November 30''.

Subsec. (d)(11)(B). Pub. L. 111–286, §2(3), substituted ''2011'' for ''remaining portion of 2010'' in heading and struck out ''the period beginning on December 1, 2010, and ending on December 31, 2010, and for'' before ''2011 and subsequent years'' in text.

Subsec. (d)(12). Pub. L. 111–309, §101, added par. (12).

Subsec. (e)(1)(A). Pub. L. 111–148, §10324(c)(1), substituted ''(H), and (I)'' for ''and (H)'' in introductory provisions.

Pub. L. 111–148, §3102(b)(1), substituted ''(G), and (H)'' for ''and (G)'' in introductory provisions.

Subsec. (e)(1)(E). Pub. L. 111–309, §103, substituted ''before January 1, 2012'' for ''before January 1, 2011''.

Pub. L. 111–148, §3102(a), substituted ''before January 1, 2011'' for ''before January 1, 2010''.

Subsec. (e)(1)(H). Pub. L. 111–148, §3102(b)(2), added subpar. (H).

Subsec. (e)(1)(H)(i). Pub. L. 111–152, §1108, substituted ''½'' for ''¾''.

Subsec. (e)(1)(I). Pub. L. 111–148, §10324(c)(2), added subpar. (I).

Subsec. (j)(3). Pub. L. 111–148, §4103(c)(2), inserted ''(2)(FF) (including administration of the health risk assessment),'' after ''(2)(EE),''.

Subsec. (k)(4). Pub. L. 111–148, §3002(c)(1), inserted ''or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry'' after ''Database)''.

Subsec. (m)(1)(A). Pub. L. 111–148, §3002(a)(1)(A), substituted ''2014'' for ''2010'' in introductory provisions.

Subsec. (m)(1)(B)(iii), (iv). Pub. L. 111–148, §3002(a)(1)(B), added cls. (iii) and (iv).

Subsec. (m)(3)(A). Pub. L. 111–148, §3002(a)(2)(A), inserted ''(or, for purposes of subsection (a)(8), for the quality reporting period for the year)'' after ''reporting period'' in introductory provisions.

Subsec. (m)(3)(C)(i). Pub. L. 111–148, §3002(a)(2)(B), inserted '', or, for purposes of subsection (a)(8), for a quality reporting period for the year'' after ''(a)(5), for a reporting period for a year''.

Subsec. (m)(5)(E). Pub. L. 111–148, §3002(f)(1), substituted ''Except as provided in subparagraph (I), there shall'' for ''There shall'' in introductory provisions.

Subsec. (m)(5)(E)(iv). Pub. L. 111–148, §3002(a)(3), substituted ''paragraphs (5)(A) and (8)(A) of subsection (a)'' for ''subsection (a)(5)(A)''.

Subsec. (m)(5)(H), (I). Pub. L. 111–148, §3002(e), (f)(2), added subpars. (H) and (I).

Subsec. (m)(6)(C)(i)(II). Pub. L. 111–148, §3002(a)(4)(A), substituted ''and subsequent years'' for '', 2009, 2010, and 2011''.

Subsec. (m)(6)(C)(iii). Pub. L. 111–148, §3002(a)(4)(B), inserted ''(a)(8)'' after ''(a)(5)'' and substituted ''under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively'' for ''under subparagraph (D)(iii) of such subsection''.

Subsec. (m)(7). Pub. L. 111–148, §10327(a), added par. (7) relating to additional incentive payment.

Pub. L. 111–148, §3002(d), added par. (7) relating to integration of physician quality reporting and EHR reporting.

Subsec. (n)(1)(A). Pub. L. 111–148, §3003(a)(1)(A), designated existing provisions as cl. (i), inserted heading, substituted ''the 'Program').'' for ''the 'Program') under which the Secretary shall use claims data under this subchapter (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this subchapter. If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this subchapter by the physician (or group of physicians) in such reports.'', and added cls. (ii) and (iii).

Subsec. (n)(1)(B). Pub. L. 111–148, §3003(a)(1)(B), substituted ''subparagraph (A)(ii)'' for ''subparagraph (A)'' in introductory provisions.

Subsec. (n)(4). Pub. L. 111–148, §3003(a)(2)(B), inserted ''initial'' after ''focus the'' in introductory provisions.

Pub. L. 111–148, §3003(a)(2)(A), inserted ''initial'' after ''focus'' in heading.

Subsec. (n)(6). Pub. L. 111–148, §3003(a)(3), inserted at end ''For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.''

Subsec. (n)(9), (10). Pub. L. 111–148, §3003(a)(4), added pars. (9) and (10).

Subsec. (*o*)(1)(C)(ii). Pub. L. 111–157, §5(a)(1), substituted ''inpatient or emergency room setting'' for ''setting (whether inpatient or outpatient)''.

Subsec. (p). Pub. L. 111–148, §3007(2), added subsec. (p).

2009—Subsec. (a)(5)(A)(i). Pub. L. 111–5, §4101(f)(1)(A), substituted '', 2013 or 2014'' for ''or any subsequent year''.

Subsec. (a)(5)(A)(ii)(III). Pub. L. 111–5, §4101(f)(1)(B), struck out ''and each subsequent year'' after ''2014''.

Subsec. (a)(7). Pub. L. 111–5, §4101(b), added par. (7).

Subsec. (d)(10). Pub. L. 111–118 added par. (10).

Subsec. (m)(2)(A). Pub. L. 111–5, §4101(f)(2)(A), substituted ''Subject to subparagraph (D), for 2009'' for ''For 2009''.

Subsec. (m)(2)(D). Pub. L. 111–5, §4101(f)(2)(B), added subpar. (D).

Subsec. (*o*). Pub. L. 111–5, §4101(a), added subsec. (*o*).

2008—Subsec. (a)(4)(A). Pub. L. 110–275, §139(a)(1), inserted ''except as provided in paragraph (5),'' after ''anesthesia cases,''.

Subsec. (a)(5). Pub. L. 110–275, §132(b), added par. (5).

Subsec. (a)(6). Pub. L. 110–275, §139(a)(2), added par. (6).

Subsec. (b)(5). Pub. L. 110–275, §144(a)(2)(B), added par. (5).

Subsec. (c)(2)(B)(vi). Pub. L. 110–275, §133(b), added cl. (vi).

Subsec. (d)(8). Pub. L. 110–275, §131(a)(1)(A)(i), struck out ''a portion of'' before ''2008'' in heading.

Subsec. (d)(8)(A). Pub. L. 110–275, §131(a)(1)(A)(ii), struck out ''for the period beginning on January 1, 2008, and ending on June 30, 2008,'' after ''for 2008,''.

Subsec. (d)(8)(B). Pub. L. 110–275, §131(a)(1)(A)(iii), struck out ''the remaining portion of 2008 and'' before ''2009'' in heading and ''for the period beginning on July 1, 2008, and ending on December 31, 2008, and'' before ''for 2009'' in text.

Subsec. (d)(9). Pub. L. 110–275, §131(a)(1)(B), added par. (9).

Subsec. (e)(1)(A). Pub. L. 110–275, §134(c), amended Pub. L. 108–173, §602(1). See 2003 Amendment note below.

Subsec. (e)(1)(E). Pub. L. 110–275, §134(a), substituted ''before January 1, 2010'' for ''before July 1, 2008''.

Subsec. (e)(1)(G). Pub. L. 110–275, §134(b), inserted at end ''For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5''.

Subsec. (j)(3). Pub. L. 110–275, §152(b)(1)(C), inserted ''(2)(EE),'' after ''(2)(DD),''.

Pub. L. 110–275, §144(a)(2)(A), inserted ''(2)(DD),'' after ''(2)(AA),''.

Subsec. (k)(2)(C), (D). Pub. L. 110–275, §131(b)(1), added subpars. (C) and (D).

Subsec. (k)(3)(B)(iv). Pub. L. 110–275, §131(b)(4)(A), added cl. (iv).

Subsec. (*l*)(2)(A)(i)(III). Pub. L. 110–275, §131(a)(3)(C)(i)(I), struck out subcl. (III) which read as follows: ''For expenditures during 2013, an amount equal to $4,670,000,000.''

Pub. L. 110–252, §7002(c)(1)(A), substituted ''$4,670,000,000'' for ''$4,960,000,000''.

Subsec. (*l*)(2)(A)(i)(IV). Pub. L. 110–275, §131(a)(3)(C)(i)(I), struck out subcl. (IV) which read as follows: ''For expenditures during 2014, an amount equal to $290,000,000.''

Pub. L. 110–252, §7002(c)(1)(B), added subcl. (IV).

Subsec. (*l*)(2)(A)(ii)(III). Pub. L. 110–275, §131(a)(3)(C)(i)(II), struck out subcl. (III). Text read as follows: ''The amount available for expenditures during 2013 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.''

Subsec. (*l*)(2)(A)(ii)(IV). Pub. L. 110–275, §131(a)(3)(C)(i)(II), struck out subcl. (IV). Text read as follows: ''The amount available for expenditures during 2014 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.''

Pub. L. 110–252, §7002(c)(2), added subcl. (IV).

Subsec. (*l*)(2)(B). Pub. L. 110–275, §131(a)(3)(C)(ii), inserted ''and'' at end of cl. (i), substituted period for semicolon at end of cl. (ii), and struck out cls. (iii) and (iv) which read as follows:

''(iii) 2013 for payment with respect to physicians' services furnished during 2013; and

''(iv) 2014 for payment with respect to physicians' services furnished during 2014.''

Subsec. (*l*)(2)(B)(iv). Pub. L. 110–252, §7002(c)(3), added cl. (iv).

Subsec. (m). Pub. L. 110–275, §131(b)(2), (3)(A), transferred subsec. (c) of section 101 of title I of div. B of Pub. L. 109–432 to subsec. (m) of this section and amended heading generally. Prior to amendment, heading read ''Transitional Bonus Incentive Payments for Quality Reporting in 2007 and 2008''. See Codification note above.

Subsec. (m)(1). Pub. L. 110–275, §131(b)(3)(B), added par. (1) and struck out former par. (1) which provided for an additional payment for certain covered professional services furnished by an eligible professional.

Subsec. (m)(2). Pub. L. 110–275, §132(a)(1), added par. (2). Former par. (2) redesignated (3).

Subsec. (m)(3). Pub. L. 110–275, §132(a)(2)(A), inserted ''and successful electronic prescriber'' after ''reporting'' in heading.

Pub. L. 110–275, §131(b)(3)(D)(i), (ii), designated existing provisions as subpar. (A) and inserted heading, redesignated former subpars. (A) and (B) as cls. (i) and (ii), respectively, of subpar. (A), and realigned margins.

Pub. L. 110–275, §131(b)(3)(C), redesignated par. (2) as (3) and struck out former par. (3) which provided for payment limitation.

Subsec. (m)(3)(A). Pub. L. 110–275, §131(b)(3)(D)(iii), inserted concluding provisions.

Subsec. (m)(3)(B). Pub. L. 110–275, §132(a)(2)(B), added subpar. (B). Former subpar. (B) redesignated cl. (i) of subpar. (A).

Subsec. (m)(3)(C), (D). Pub. L. 110–275, §131(b)(3)(D)(iv), added subpars. (C) and (D).

Subsec. (m)(5)(A). Pub. L. 110–275, §131(b)(5)(A)(i), substituted ''subsection (k)'' for ''section 1848(k) of the So-

cial Security Act, as added by subsection (b),'' and ''such subsection'' for ''such section''.

Subsec. (m)(5)(B). Pub. L. 110–275, §131(b)(5)(A)(ii), struck out ''of the Social Security Act (42 U.S.C. 1395*l*)'' before ''and any payment''.

Subsec. (m)(5)(C). Pub. L. 110–275, §131(b)(3)(E)(i), inserted ''for 2007, 2008, and 2009,'' after ''provision of law,''.

Subsec. (m)(5)(D)(i). Pub. L. 110–275, §131(b)(3)(E)(ii)(I), which directed amendment of cl. (i) by inserting ''for 2007 and 2008'' after ''under this subsection'' and then substituting ''this subsection'' for ''paragraph (2)'', was executed by substituting ''under this subsection for 2007 and 2008'' for ''under paragraph (2)'' to reflect the probable intent of Congress.

Subsec. (m)(5)(D)(ii). Pub. L. 110–275, §131(b)(3)(E)(ii)(II), substituted ''may establish procedures to'' for ''shall''.

Subsec. (m)(5)(D)(iii). Pub. L. 110–275, §131(b)(3)(E)(ii)(III), inserted ''(or, in the case of a group practice under paragraph (3)(C), the group practice)'' after ''an eligible professional'', substituted ''incentive payment under this subsection'' for ''bonus incentive payment'', and inserted at end ''If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).''

Subsec. (m)(5)(E). Pub. L. 110–275, §131(b)(5)(A)(iii), substituted ''1395ff of this title, section 1395*oo* of this title, or otherwise'' for ''1869 or 1878 of the Social Security Act or otherwise''.

Pub. L. 110–275, §131(b)(3)(E)(iii)(I)–(III), struck out cl. (i) designation and heading before ''There shall be'', redesignated subcls. (I) to (IV) as cls. (i) to (iv), respectively, and struck out former cl. (ii). Prior to amendment, text of cl. (ii) read as follows: ''A determination under this subsection shall not be treated as a determination for purposes of section 1869 of the Social Security Act.''

Subsec. (m)(5)(E)(ii). Pub. L. 110–275, §131(b)(3)(E)(iii)(IV), substituted ''this subsection'' for ''paragraph (2)''.

Subsec. (m)(5)(E)(iii). Pub. L. 110–275, §132(a)(3), added cl. (iii) and struck out former cl. (iii) which read as follows: ''the determination of the payment limitation under paragraph (3); and''.

Subsec. (m)(5)(E)(iv). Pub. L. 110–275, §131(b)(3)(E)(iii)(V), substituted ''any'' for ''the bonus'' and inserted ''and the payment adjustment under subsection (a)(5)(A)'' before period at end.

Subsec. (m)(5)(F). Pub. L. 110–275, §131(b)(3)(E)(iv), (5)(A)(iv), substituted ''subsequent years,'' for ''2009, paragraph (3) shall not apply, and'', ''this subsection'' for ''paragraph (2)'', ''subsection (k)(2)(B)'' for ''paragraph (2)(B) of section 1848(k)'' of the Social Security Act (42 U.S.C. 1395w–4(k))'', and ''subsection (k)(4)'' for ''paragraph (4) of such section''.

Subsec. (m)(5)(G). Pub. L. 110–275, §131(b)(3)(E)(v), added subpar. (G).

Subsec. (m)(6)(A). Pub. L. 110–275, §131(b)(5)(B)(i), substituted ''subsection (k)(3)'' for ''section 1848(k)(3) of the Social Security Act, as added by subsection (b)''.

Subsec. (m)(6)(B). Pub. L. 110–275, §131(b)(5)(B)(ii), substituted ''subsection (k)'' for ''section 1848(k) of the Social Security Act, as added by subsection (b)''.

Subsec. (m)(6)(C). Pub. L. 110–275, §131(b)(3)(F), added subpar. (C) and struck out former subpar. (C). Prior to amendment, text read as follows: ''The term 'reporting period' means—

''(i) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

''(ii) for 2008, all of 2008.''

Subsec. (m)(6)(D). Pub. L. 110–275, §131(b)(5)(C), struck out subpar. (D). Text read as follows: ''The term 'Secretary' means the Secretary of Health and Human Services.''

Subsec. (n). Pub. L. 110–275, §131(c)(1), added subsec. (n).

2007—Subsec. (d)(4)(B). Pub. L. 110–173, §101(a)(1)(A), substituted ''and the succeeding paragraphs of this subsection'' for ''and paragraphs (5) and (6)'' in introductory provisions.

Subsec. (d)(8). Pub. L. 110–173, §101(a)(1)(B), added par. (8).

Subsec. (e)(1)(E). Pub. L. 110–173, §103, substituted ''before July 1, 2008'' for ''before January 1, 2008''.

Subsec. (k)(2)(B). Pub. L. 110–173, §101(b)(1), in heading and cl. (i), inserted ''and 2009'' after ''2008'', and, in cls. (ii) and (iii), substituted ''of each of 2007 and 2008'' for '', 2007'' and inserted ''or 2009, as applicable'' after ''2008''.

Subsec. (*l*)(2)(A). Pub. L. 110–173, §101(a)(2)(A)(i), added subpar. (A) and struck out former subpar. (A), which read as follows: ''There shall be available to the Fund for expenditures an amount equal to $1,200,000,000, as reduced by section 524 and section 225(c)(1)(A) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008). In addition, there shall be available to the Fund for expenditures during 2009 an amount equal to $325,000,000, as reduced by section 225(c)(1)(B) of such Act, and for expenditures during or after 2013 an amount equal to $60,000,000.''

Pub. L. 110–161, §524, which directed amendment of subpar. (A) by reducing the dollar amount in the first sentence by $150,000,000, was executed by substituting ''$1,200,000,000'' for ''$1,350,000,000'' in first sentence.

Pub. L. 110–161, §225(c)(2), inserted, in first sentence, '', as reduced by section 524 and section 225(c)(1)(A) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008)'' after ''$1,350,000,000'' and, in second sentence, '', as reduced by section 225(c)(1)(B) of such Act,'' after ''$325,000,000''.

Pub. L. 110–90, §6(1), inserted at end: ''In addition, there shall be available to the Fund for expenditures during 2009 an amount equal to $325,000,000 and for expenditures during or after 2013 an amount equal to $60,000,000.''

Subsec. (*l*)(2)(B). Pub. L. 110–173, §101(a)(2)(A)(ii), substituted ''entire amount available for expenditures, after application of subparagraph (A)(ii), during—'' and cls. (i) to (iii) for ''entire amount specified in the first sentence of subparagraph (A) for payment with respect to physicians' services furnished during 2008 and for the obligation of the entire first amount specified in the second sentence of such subparagraph for payment with respect to physicians' services furnished during 2009 and of the entire second amount so specified for payment with respect to physicians' services furnished on or after January 1, 2013.''

Pub. L. 110–90, §6(2), in heading, struck out ''furnished during 2008'' after ''services'' and, in text, substituted ''specified in the first sentence of subparagraph (A)'' for ''specified in subparagraph (A)'' and inserted ''and for the obligation of the entire first amount specified in the second sentence of such subparagraph for payment with respect to physicians' services furnished during 2009 and of the entire second amount so specified for payment with respect to physicians' services furnished on or after January 1, 2013'' after ''furnished during 2008''.

2006—Subsec. (b)(4). Pub. L. 109–171, §5102(b)(1), added par. (4).

Subsec. (c)(2)(B)(ii)(II). Pub. L. 109–171, §5102(a)(1), substituted ''clauses (iv) and (v)'' for ''clause (iv)''.

Subsec. (c)(2)(B)(iv). Pub. L. 109–171, §5102(a)(2), inserted ''of certain additional expenditures'' after ''Exemption'' in heading.

Subsec. (c)(2)(B)(v). Pub. L. 109–171, §5102(a)(3), added cl. (v).

Subsec. (c)(2)(B)(v)(II). Pub. L. 109–171, §5102(b)(2), added subcl. (II).

Subsec. (d)(4)(B). Pub. L. 109–171, §5104(a)(1), substituted ''paragraphs (5) and (6)'' for ''paragraph (5)'' in introductory provisions.

Subsec. (d)(6). Pub. L. 109–171, §5104(a)(2), added par. (6).

Subsec. (d)(7). Pub. L. 109–432, §101(a), added par. (7).

Subsec. (e)(1)(E). Pub. L. 109–432, §102, substituted ''2008'' for ''2007''.

Subsec. (j)(3). Pub. L. 109–171, §5112(c), inserted ''(2)(AA),'' after ''(2)(W),''.

Subsec. (k). Pub. L. 109–432, §101(b), added subsec. (k).

Subsec. (*l*). Pub. L. 109–432, §101(d), added subsec. (*l*).

2003—Subsec. (c)(2)(B)(ii)(II). Pub. L. 108–173, §303(a)(1)(A)(i), substituted ''Subject to clause (iv), the adjustments'' for ''The adjustments''.

Subsec. (c)(2)(B)(iv). Pub. L. 108–173, §303(a)(1)(A)(ii), added cl. (iv).

Subsec. (c)(2)(H) to (J). Pub. L. 108–173, §303(a)(1)(B), added subpars. (H) to (J).

Subsec. (d)(4)(B). Pub. L. 108–173, §601(a)(2), inserted ''and paragraph (5)'' after ''subparagraph (D)'' in introductory provisions.

Subsec. (d)(5). Pub. L. 108–173, §601(a)(1), added par. (5).

Subsec. (e)(1)(A). Pub. L. 108–173, §602(1), as amended by Pub. L. 110–275, §134(c), substituted ''subparagraphs (B), (C), (E), and (G)'' for ''subparagraphs (B), (C), and (E)''.

Pub. L. 108–173, §412(1), substituted ''subparagraphs (B), (C), and (E)'' for ''subparagraphs (B) and (C)''.

Subsec. (e)(1)(E). Pub. L. 108–173, §412(2), added subpar. (E).

Subsec. (e)(1)(G). Pub. L. 108–173, §602(2), added subpar. (G).

Subsec. (f)(2)(C). Pub. L. 108–173, §601(b)(1), substituted ''annual average'' for ''projected'' and ''during the 10-year period ending with the applicable period involved'' for ''from the previous applicable period to the applicable period involved''.

Subsec. (i)(1)(B). Pub. L. 108–173, §303(g)(2), substituted ''subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I)'' for ''subsection (c)(2)(F)''.

Subsec. (i)(1)(C). Pub. L. 108–7 amended subpar. (C) generally. Prior to amendment, subpar. (C) read as follows: ''the determination of conversion factors under subsection (d) of this section,''.

Subsec. (i)(3)(A). Pub. L. 108–173, §736(b)(10), substituted ''comparable services'' for ''a comparable services''.

Subsec. (j)(3). Pub. L. 108–173, §611(c), inserted ''(2)(W),'' after ''(2)(S),''.

2000—Subsec. (j)(3). Pub. L. 106–554 inserted ''(13),'' after ''(4),''.

1999—Subsec. (d)(1)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(A)(i)], inserted ''(for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved'' before period at end.

Subsec. (d)(1)(E). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(2)(A)], amended heading and text of subpar. (E) generally. Prior to amendment, text read as follows: ''The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

''(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update determined under paragraph (3) for 1992; and

''(ii) each succeeding year, the conversion factor which will apply to physicians' services for the following year and the update determined under paragraph (3) for such year.''

Subsec. (d)(3). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(i)], inserted ''for 1999 and 2000'' after ''Update'' in heading.

Subsec. (d)(3)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(ii)], substituted ''1999 and 2000'' for ''a year beginning with 1999'' in introductory provisions.

Subsec. (d)(3)(C). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(A)(iii)], inserted ''and paragraph (4)'' after ''For purposes of this paragraph'' in introductory provisions.

Subsec. (d)(4). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(1)(B)], added par. (4).

Subsec. (f)(1). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(1)], amended heading and text of par. (1) generally. Prior to amendment, text read as follows: ''The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur by not later than August 1 before each fiscal year, except that such rate for fiscal year 1998 shall be published not later than November 1, 1997.''

Subsec. (f)(2). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(A)], substituted ''fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000'' for ''fiscal year 1998)'' in introductory provisions.

Subsec. (f)(2)(A). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(B)], substituted ''applicable period'' for ''fiscal year''.

Subsec. (f)(2)(B), (C). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(2)(B)], substituted ''applicable period'' for ''fiscal year'' in two places.

Subsec. (f)(2)(D). Pub. L. 106–113, §1000(a)(6) [title II, §211(a)(3)(A)(ii), (b)(2)(B)], substituted ''applicable period'' for ''fiscal year'' in two places and ''subsection (d)(3)(B) or (d)(4)(B), as the case may be'' for ''subsection (d)(3)(B)''.

Subsec. (f)(3). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(5)], added par. (3). Former par. (3) redesignated (4).

Subsec. (f)(3)(C). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(3)], added subpar. (C).

Subsec. (f)(4). Pub. L. 106–113, §1000(a)(6) [title II, §211(b)(4)], redesignated par. (3) as (4).

Subsec. (j)(3). Pub. L. 106–113, §1000(a)(6) [title III, §321(k)(5)], substituted ''section 1395x(*oo*)(2) of this title)'' for ''section 1395x(*oo*)(2) of this title,'', ''(B),'' for ''(B),'', and '', and (15)'' for ''and (15)''.

1997—Subsec. (b)(1). Pub. L. 105–33, §4644(d), substituted ''Before November 1 of the preceding year, for each year beginning with 1998'' for ''Before January 1 of each year beginning with 1992'' in introductory provisions.

Subsec. (c)(2)(B)(iii). Pub. L. 105–33, §4022(b)(2)(C), substituted ''Medicare Payment Advisory Commission'' for ''Physician Payment Review Commission''.

Subsec. (c)(2)(C)(ii). Pub. L. 105–33, §4505(b)(1)(A), which directed an amendment striking the comma at the end of cl. (ii) and inserting a period and the following: ''For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.'', was executed by making the insertion at end of cl. (ii) to reflect the probable intent of Congress, because cl. (ii) ended with a period rather than a comma.

Pub. L. 105–33, §4505(a)(1), substituted ''1999'' for ''1998'' in two places.

Subsec. (c)(2)(C)(iii). Pub. L. 105–33, §4505(f)(1)(A), inserted ''for the service for years before 2000'' before ''equal'' in introductory provisions, substituted comma for period at end of subcl. (II), and inserted concluding provisions.

Subsec. (c)(2)(G). Pub. L. 105–33, §4505(e), added subpar. (G).

Subsec. (c)(3)(C)(ii). Pub. L. 105–33, §4505(b)(2), substituted ''2002'' for ''1999'' in introductory provisions.

Pub. L. 105–33, §4505(a)(2), substituted ''1999'' for ''1998'' in introductory provisions.

Subsec. (c)(3)(C)(iii). Pub. L. 105–33, §4505(f)(1)(B), substituted ''For years before 1999, the malpractice'' for ''The malpractice'' in introductory provisions.

Subsec. (d)(1)(A). Pub. L. 105–33, §4501(b)(1), (2), struck out ''(or factors)'' after ''conversion factor'' in two places and struck out ''or updates'' after ''update''.

Subsec. (d)(1)(C). Pub. L. 105–33, §4504(a)(1), substituted ''Except as provided in subparagraph (D), the single conversion factor'' for ''The single conversion factor''.

Pub. L. 105–33, § 4501(a)(2), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (d)(1)(D). Pub. L. 105–33, § 4504(a)(3), added subpar. (D). Former subpar. (D) redesignated (E).

Pub. L. 105–33, § 4501(b)(1), (3), struck out ''(or updates)'' after ''update'' in two places and struck out ''(or factors)'' after ''conversion factor'' in cl. (ii).

Pub. L. 105–33, § 4501(a)(1), redesignated subpar. (C) as (D).

Subsec. (d)(1)(E). Pub. L. 105–33, § 4504(a)(2), redesignated subpar. (D) as (E).

Subsec. (d)(2). Pub. L. 105–33, § 4502(b), struck out heading and text of par. (2) which related to recommendation of update.

Subsec. (d)(2)(F). Pub. L. 105–33, § 4022(b)(1)(B)(i), struck out heading and text of subpar. (F). Text read as follows: ''The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.''

Subsec. (d)(3). Pub. L. 105–33, § 4502(a)(1), amended heading and text generally. Prior to amendment, text related to updates of conversion factor based on index and made provision for adjustments in update.

Subsec. (f). Pub. L. 105–33, § 4503(b), amended subsec. heading and heading and text of par. (1) generally. Prior to amendment, par. (1) related to process for establishing medicare volume performance standard rates of increase.

Subsec. (f)(1)(B). Pub. L. 105–33, § 4022(b)(2)(B)(ii), struck out heading and text of subpar. (B). Text read as follows: ''The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.''

Subsec. (f)(2). Pub. L. 105–33, § 4503(a), added par. (2) and struck out heading and text of former par. (2) which related to specification of performance standard rates of increase for physician services for fiscal years beginning in 1991.

Subsec. (f)(3). Pub. L. 105–33, § 4503(a), added par. (3) and struck out heading and text of former par. (3). Text read as follows: ''The Secretary shall establish procedures for providing, on a quarterly basis to the the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.''

Pub. L. 105–33, § 4022(b)(2)(B)(iii), struck out ''Physician Payment Review Commission,'' before ''the Congressional Budget Office''.

Subsec. (f)(4), (5). Pub. L. 105–33, § 4503(a), struck out heading and text of par. (4) which related to separate group-specific performance standard rates of increase and par. (5) which defined ''physicians' services'' and ''HMO enrollee''.

Subsec. (g)(3)(A). Pub. L. 105–33, § 4714(b)(2), inserted before period at end ''and the provisions of section 1396a(n)(3)(A) of this title apply to further limit permissible charges under this section''.

Subsec. (g)(6)(C), (7)(C). Pub. L. 105–33, § 4022(b)(2)(C), substituted ''Medicare Payment Advisory Commission'' for ''Physician Payment Review Commission''.

Subsec. (j)(1). Pub. L. 105–33, § 4501(b)(4), substituted ''For services furnished before January 1, 1998, the term'' for ''The term''.

Subsec. (j)(3). Pub. L. 105–33, § 4106(b), substituted ''(4), (14)'' for ''(4) and (14)'' and inserted ''and (15)'' after ''1395x(nn)(2) of this title)''.

Pub. L. 105–33, § 4105(a)(2), inserted ''(2)(S),'' before ''(3)''.

Pub. L. 105–33, § 4103(d), inserted ''(2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1395x(*oo*)(2) of this title,'' after ''(2)(G)''.

Pub. L. 105–33, §§ 4102(d), 4104(d), inserted ''(2)(R) (with respect to services described in subparagraphs (B) , (C), and (D) of section 1395x(pp)(1) of this title),'' before ''(3)'' and substituted ''(4) and (14) (with respect to services described in section 1395x(nn)(2) of this title)'' for ''and (4)''.

1994—Subsec. (a)(2)(D)(iii). Pub. L. 103–432, § 126(b)(6), struck out ''that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989'' after ''nuclear medicine services'' and substituted ''provided under section 6105(b) of the Omnibus Budget Reconciliation Act of 1989'' for ''provided under such section''.

Subsec. (c)(2)(C)(ii). Pub. L. 103–432, § 121(b)(1), inserted ''for the service for years before 1998'' before ''equal to'' in introductory provisions, substituted comma for period at end of subcl. (II), and inserted ''and for years beginning with 1998 based on the relative practice expense resources involved in furnishing the service.'' as closing provisions.

Subsec. (c)(3)(C)(ii). Pub. L. 103–432, § 121(b)(2), substituted ''For years before 1998, the practice'' for ''The practice''.

Subsec. (c)(4). Pub. L. 103–432, § 126(g)(6), made technical amendment to directory language of Pub. L. 101–508, § 4118(f)(1)(D). See 1990 Amendment note below.

Subsec. (e)(1)(C). Pub. L. 103–432, § 126(g)(5), inserted ''date of the'' before ''last previous adjustment''.

Pub. L. 103–432, § 122(a), substituted ''shall, in consultation with appropriate representatives of physicians, review'' for ''shall review''.

Subsec. (e)(1)(D). Pub. L. 103–432, § 122(b), added subpar. (D).

Subsec. (f)(2)(A)(i). Pub. L. 103–432, § 126(g)(7), made technical amendment to directory language of Pub. L. 101–508, § 4118(f)(1)(N)(ii). See 1990 Amendment note below.

Subsec. (f)(2)(C). Pub. L. 103–432, § 126(g)(2)(B), inserted heading.

Subsec. (g)(1). Pub. L. 103–432, § 123(a)(1), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: ''If a nonparticipating physician or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title) knowingly and willfully bills on a repeated basis for physicians' services (including services which the Secretary excludes pursuant to subsection (j)(3) of this section, furnished with respect to an individual enrolled under this part on or after January 1, 1991) an actual charge in excess of the limiting charge described in paragraph (2) and for which payment is not made on an assignment-related basis under this part, the Secretary may apply sanctions against such physician, supplier, or other person in accordance with section 1395u(j)(2) of this title. In applying this subparagraph, any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.''

Subsec. (g)(3)(B). Pub. L. 103–432, § 123(a)(2), inserted after first sentence ''No person is liable for payment of any amounts billed for such a service in violation of the previous sentence.'' and in last sentence substituted ''first sentence'' for ''previous sentence''.

Subsec. (g)(6)(B). Pub. L. 103–432, § 123(d), inserted ''information on the extent to which actual charges exceed limiting charges, the number and types of services involved, and the average amount of excess charges and information'' after ''report to the Congress''.

Subsec. (i)(3). Pub. L. 103–432, § 126(g)(10)(A), struck out space before the period at end.

1993—Subsec. (a)(2)(B)(ii)(I). Pub. L. 103–66, § 13515(c)(1), inserted ''and under section 13515(b) of the Omnibus Budget Reconciliation Act of 1993'' after ''subsection (c)(2)(F)(ii)''.

Pub. L. 103–66, § 13514(c)(1), inserted ''and as adjusted under subsection (c)(2)(F)(ii)'' after ''for 1994''.

Subsec. (a)(3). Pub. L. 103–66, § 13517(a)(1), in heading inserted ''and suppliers'' after ''physicians'' and in text inserted ''or a nonparticipating supplier or other person'' after ''nonparticipating physician'' and inserted at end ''In the case of physicians' services (including

services which the Secretary excludes pursuant to subsection (j)(3)) of a nonparticipating physician, supplier, or other person for which payment is made under this part on a basis other than the fee schedule amount, the payment shall be based on 95 percent of the payment basis for such services furnished by a participating physician, supplier, or other person.''

Subsec. (a)(4). Pub. L. 103–66, § 13516(a)(1), added par. (4).

Pub. L. 103–66, § 13515(a)(1), struck out heading and text of par. (4). Text read as follows: ''In the case of physicians' services furnished by a physician before the end of the physician's first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1395ww(d)(2) of this title) that is designated under section 249(a)(1)(A) of this title as a health manpower shortage area.''

Subsec. (b)(3). Pub. L. 103–66, § 13514(a), amended heading and text of par. (3) generally. Prior to amendment, text read as follows: ''If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1395u(j)(2) of this title.''

Subsec. (c)(2)(A)(i). Pub. L. 103–66, § 13515(c)(2), inserted before period at end ''and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993''.

Pub. L. 103–66, § 13514(c)(2), inserted at end ''Such relative values are subject to adjustment under subparagraph (F)(i).''

Subsec. (c)(2)(E). Pub. L. 103–66, § 13513, added subpar. (E).

Subsec. (c)(2)(F). Pub. L. 103–66, § 13514(b), added subpar. (F).

Subsec. (d)(3)(A)(i). Pub. L. 103–66, § 13511(a)(1)(A), substituted ''clauses (iii) through (v)'' for ''clause (iii)''.

Subsec. (d)(3)(A)(iv) to (vi). Pub. L. 103–66, § 13511(a)(1)(B), added cls. (iv) to (vi).

Subsec. (d)(3)(B)(ii). Pub. L. 103–66, § 13512(b), substituted ''1994'' for ''1994 or 1995'' in subcl. (II) and ''5'' for ''3'' in subcl. (III).

Subsec. (f)(2)(B). Pub. L. 103–66, § 13512(a), added cls. (iii) to (v) and struck out former cl. (iii) which read as follows: ''for each succeeding year is 2 percentage points.''

Subsec. (g)(1). Pub. L. 103–66, § 13517(a)(2)(C), (D), inserted '', supplier, or other person'' after ''such physician'' and inserted at end ''In applying this subparagraph, any reference in such section to a physician is deemed also to include a reference to a supplier or other person under this subparagraph.''

Pub. L. 103–66, § 13517(a)(2)(B), which directed insertion of ''including services which the Secretary excludes pursuant to subsection (j)(3) of this section,'' after ''physician's services ('', was executed by making the insertion after ''physicians' services ('' to reflect the probable intent of Congress.

Pub. L. 103–66, § 13517(a)(2)(A), inserted ''or nonparticipating supplier or other person (as defined in section 1395u(i)(2) of this title)'' after ''nonparticipating physician''.

Subsec. (g)(2)(C). Pub. L. 103–66, § 13517(a)(3), inserted ''or for nonparticipating suppliers or other persons'' after ''nonparticipating physicians''.

Subsec. (g)(2)(D). Pub. L. 103–66, § 13517(a)(4), inserted ''(or, if payment under this part is made on a basis other than the fee schedule under this section, 95 percent of the other payment basis)'' after ''subsection (a)''.

Subsec. (h). Pub. L. 103–66, § 13517(a)(5), inserted ''or nonparticipating supplier or other person furnishing physicians' services (as defined in subsection (j)(3))'' after ''each physician'', inserted '', supplier, or other person'' after ''by the physician'', and inserted '', suppliers, and other persons'' after ''notices to physicians''.

Subsec. (i)(1)(B). Pub. L. 103–66, § 13515(c)(3), inserted ''and section 13515(b) of the Omnibus Budget Reconciliation Act of 1993'' after ''subsection (c)(2)(F)''.

Pub. L. 103–66, § 13514(c)(3), inserted at end ''including adjustments under subsection (c)(2)(F),''.

Subsec. (j)(1). Pub. L. 103–66, § 13511(a)(2), substituted ''Secretary and including anesthesia services), primary care services (as defined in section 1395u(i)(4) of this title),'' for ''Secretary)''.

Subsec. (j)(3). Pub. L. 103–66, § 13518(a), inserted ''(2)(G),'' after ''(2)(D),''.

Pub. L. 103–66, § 13517(a)(6), inserted '', except for purposes of subsections (a)(3), (g), and (h)'' after ''tests and''.

1990—Subsec. (a)(1). Pub. L. 101–508, § 4104(b)(2), struck out ''or 1395m(f)'' after ''section 1395m(b)'' in introductory provisions.

Subsec. (a)(2)(C). Pub. L. 101–508, § 4102(b), inserted ''and radiology'' after ''Special rule for anesthesia'' in heading and inserted at end ''With respect to radiology services, '109 percent' and '9 percent' shall be substituted for '115 percent' and '15 percent', respectively, in subparagraph (A)(ii).''

Subsec. (a)(2)(D)(ii). Pub. L. 101–508, § 4102(g)(2)(A), inserted '', but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989'' after ''section 1395m(b)(6) of this title)''.

Subsec. (a)(2)(D)(iii). Pub. L. 101–508, § 4102(g)(2)(B), added cl. (iii).

Subsec. (a)(4). Pub. L. 101–508, § 4106(b)(1), added par. (4).

Subsec. (b)(3). Pub. L. 101–508, § 4109(a), added par. (3).

Subsec. (c)(1)(B). Pub. L. 101–508, § 4118(f)(1)(A), struck out at end ''In this subparagraph, the term 'practice expenses' includes all expenses for furnishing physicians' services, excluding malpractice expenses, physician compensation, and other physician fringe benefits.''

Subsec. (c)(3). Pub. L. 101–508, § 4118(f)(1)(C), redesignated par. (3), relating to ancillary policies, as (4).

Subsec. (c)(3)(C)(ii)(II), (iii)(II). Pub. L. 101–508, § 4118(f)(1)(B), struck out ''by'' before ''the proportion''.

Subsec. (c)(4). Pub. L. 101–508, § 4118(f)(1)(D), as amended by Pub. L. 103–432, § 126(g)(6), substituted ''section'' for ''subsection''.

Pub. L. 101–508, § 4118(f)(1)(C), redesignated par. (3), relating to ancillary policies, as (4). Former par. (4) redesignated (5).

Pub. L. 101–508, § 4118(d), struck out ''only for services furnished on or after January 1, 1993'' after ''visits and consultations''.

Subsec. (c)(5), (6). Pub. L. 101–508, § 4118(f)(1)(C), redesignated pars. (4) and (5) as (5) and (6), respectively.

Subsec. (d)(1)(A). Pub. L. 101–508, § 4118(f)(1)(E), (F)(i)(III), amended subpar. (A) identically, substituting ''paragraph (3)'' for ''subparagraph (C)''.

Pub. L. 101–508, § 4118(f)(1)(F)(i)(I), (II), substituted ''conversion factor (or factors)'' for ''conversion factor'' in two places and ''update or updates'' for ''update''.

Subsec. (d)(1)(C)(i). Pub. L. 101–508, § 4118(f)(1)(F)(ii)(I), substituted ''conversion factor'' for ''conversion factor (or factors)''.

Subsec. (d)(1)(C)(ii). Pub. L. 101–508, § 4118(f)(1)(F)(ii)(II), inserted ''the conversion factor (or factors) which will apply to physicians' services for the following year and'' before ''the update (or updates)'' and substituted ''such year'' for ''the following year''.

Subsec. (d)(2)(A). Pub. L. 101–508, § 4118(f)(1)(G), (I), substituted ''physicians' services (as defined in subsection (f)(5)(A) of this section)'' for ''physicians' serv-

ices'' in first sentence and ''proportion of individuals who are enrolled under this part who are HMO enrollees'' for ''proportion of HMO enrollees'' in last sentence.

Subsec. (d)(2)(A)(ii). Pub. L. 101–508, §4118(f)(1)(H), substituted ''and for the services involved'' for ''(as defined in subsection (f)(5)(A) of this section)'' and ''such services'' for ''all such physicians' services''.

Subsec. (d)(2)(E)(i). Pub. L. 101–508, §4118(f)(1)(J), inserted ''the'' before ''most recent''.

Subsec. (d)(2)(E)(ii)(I). Pub. L. 101–508, §4118(f)(1)(K), substituted ''payments for physicians' services'' for ''physicians' services''.

Subsec. (d)(3)(A)(i). Pub. L. 101–508, §4105(a)(3)(A), inserted ''except as provided in clause (iii),'' after ''subparagraph (B),''.

Subsec. (d)(3)(A)(iii). Pub. L. 101–508, §4105(a)(3)(B), added cl. (iii).

Subsec. (d)(3)(B)(i). Pub. L. 101–508, §4118(f)(1)(L)(i)(II), which directed amendment of cl. (i) by substituting ''services in such category'' for ''physicians' services (as defined in subsection (f)(5)(A))'', was executed by making the substitution for ''physicians' services (as defined in section (f)(5)(A))'' to reflect the probable intent of Congress.

Pub. L. 101–508, §4118(f)(1)(L)(i)(I), substituted ''update for a category of physicians' services for a year'' for ''update for a year''.

Subsec. (d)(3)(B)(ii). Pub. L. 101–508, §4118(f)(1)(L)(ii), inserted ''more than'' after ''decrease of'' in introductory provisions and struck out ''more than'' before ''2 percentage points'' in subcl. (I).

Subsec. (e)(1)(A). Pub. L. 101–508, §4118(c)(1), substituted ''subparagraphs (B) and (C)'' for ''subparagraph (B)'' in introductory provisions.

Subsec. (e)(1)(C). Pub. L. 101–508, §4118(c)(2), added subpar. (C).

Subsec. (f)(1)(C). Pub. L. 101–508, §4105(c)(1), substituted ''1991'' for ''1990'' after ''beginning with''.

Subsec. (f)(1)(D)(i). Pub. L. 101–508, §4118(f)(1)(M), substituted ''portions of calendar years'' for ''calendar years''.

Subsec. (f)(2)(A). Pub. L. 101–508, §4118(b)(1), (f)(1)(N)(i), in introductory provisions, substituted ''the performance standard rate of increase, for all physicians' services and for each category of physicians' services,'' for ''each performance standard rate of increase'' and ''product'' for ''sum''.

Pub. L. 101–508, §4118(b)(6), substituted ''minus 1, multiplied by 100, and reduced'' for ''reduced'' in concluding provisions.

Subsec. (f)(2)(A)(i). Pub. L. 101–508, §4118(f)(1)(N)(ii), as amended by Pub. L. 103–432, §126(g)(7), substituted ''all physicians' services or for the category of physicians' services, respectively,'' for ''physicians' services (as defined in subsection (f)(5)(A) of this section)''.

Pub. L. 101–508, §4118(f)(1)(M), substituted ''portions of calendar years'' for ''calendar years''.

Pub. L. 101–508, §4118(b)(2), (3), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and ''percentage increase (divided by 100)'' for ''percentage increase''.

Subsec. (f)(2)(A)(ii). Pub. L. 101–508, §4118(b)(2), (4), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and inserted ''(divided by 100)'' after ''decrease''.

Subsec. (f)(2)(A)(iii). Pub. L. 101–508, §4118(f)(1)(N)(iii), substituted ''all physicians' services or of the category of physicians' services, respectively,'' for ''physicians' services''.

Pub. L. 101–508, §4118(b)(2), (5), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and inserted ''(divided by 100)'' after ''percentage growth''.

Subsec. (f)(2)(A)(iv). Pub. L. 101–508, §4118(e), (f)(1)(N)(iv), substituted ''all physicians' services or of the category of physicians' services, respectively,'' for ''physicians' services (as defined in subsection (f)(5)(A) of this section)'' and inserted ''including changes in law and regulations affecting the percentage increase described in clause (i)'' after ''law or regulations''.

Pub. L. 101–508, §4118(b)(2), (4), substituted ''1 plus the Secretary's'' for ''the Secretary's'' and ''decrease (divided by 100)'' for ''decrease''.

Subsec. (f)(2)(C). Pub. L. 101–508, §4105(c)(2), added subpar. (C).

Subsec. (f)(4)(A). Pub. L. 101–508, §4118(f)(1)(O), substituted ''subparagraph (B)'' for ''paragraph (B)''.

Subsec. (f)(4)(B). Pub. L. 101–508, §4118(f)(1)(P), substituted ''specifically approved by law'' for ''Congress specifically approves the plan''.

Subsec. (g)(2)(A). Pub. L. 101–508, §4118(f)(1)(Q), inserted ''other than radiologist services subject to section 1395m(b) of this title,'' after ''during 1991,'' in introductory provisions.

Pub. L. 101–508, §4116, inserted at end ''In the case of evaluation and management services (as specified in section 1395u(b)(16)(B)(ii) of this title), the preceding sentence shall be applied by substituting '40 percent' for '25 percent'.''

Subsec. (g)(2)(B). Pub. L. 101–508, §4118(f)(1)(Q), inserted ''other than radiologist services subject to section 1395m(b) of this title,'' after ''during 1992,'' in introductory provisions.

Subsec. (i)(1)(A). Pub. L. 101–508, §4118(f)(1)(R), substituted ''adjusted historical payment basis (as defined in subsection (a)(2)(D)(i)'' for ''historical payment basis (as defined in subsection (a)(2)(C)(i)''.

Subsec. (i)(2). Pub. L. 101–508, §4107(a)(1), added par. (2).

Subsec. (i)(3). Pub. L. 101–508, §4118(k), added par. (3).

Subsec. (j)(1). Pub. L. 101–508, §4118(f)(1)(S), which directed the amendment of par. (1) by substituting ''(as defined by the Secretary) and all other physicians' services'' for '', and such other'' and all that follows through the period was executed by making the substitution for '', and such other category or categories of physicians' services as the Secretary, from time to time, defines in regulation.'' to reflect the probable intent of Congress.

Statutory Notes and Related Subsidiaries

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.

EFFECTIVE DATE OF 2015 AMENDMENT

Pub. L. 114–10, title I, §106(b)(2)(C), Apr. 16, 2015, 129 Stat. 140, provided that: ''The amendments made by this subsection [amending this section and section 1395ww of this title] shall apply to meaningful EHR users [which term has the meaning given under 42 U.S.C. 1395f(*l*)(3), 42 U.S.C. 1395w–4(*o*), 42 U.S.C. 1395w–23(*l*), (m), and 42 U.S.C. 1395ww(n)] as of the date that is one year after the date of the enactment of this Act [Apr. 16, 2015].''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–157, §5(b), Apr. 15, 2010, 124 Stat. 1117, provided that: ''The amendments made by subsection (a) [amending this section and section 1396b of this title] shall be effective as if included in the enactment of the HITECH Act [Pub. L. 111–5, div. A, title XIII, div. B, title IV] (included in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5)).''

Pub. L. 111–152, title I, §1108, Mar. 30, 2010, 124 Stat. 1050, provided that the amendment made by section 1108 is effective as if included in the enactment of the Patient Protection and Affordable Care Act (Pub. L. 111–148).

Pub. L. 111–148, title III, §3002(c)(2), Mar. 23, 2010, 124 Stat. 365, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply for years after 2010.''

Amendment by section 4103(c)(2) of Pub. L. 111–148 applicable to services furnished on or after Jan. 1, 2011, see section 4103(e) of Pub. L. 111–148, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–275, title I, §144(a)(3), July 15, 2008, 122 Stat. 2547, provided that: ''The amendments made by this subsection [amending this section and section 1395x of this title] shall apply to items and services furnished on or after January 1, 2010.''

Pub. L. 110–275, title I, §152(b)(2), July 15, 2008, 122 Stat. 2553, provided that: ''The amendments made by this subsection [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2010.''

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–173, title I, §101(a)(2)(B), Dec. 29, 2007, 121 Stat. 2494, provided that:

''(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Dec. 29, 2007].

''(ii) SPECIAL RULE FOR COORDINATION WITH CONSOLIDATED APPROPRIATIONS ACT, 2008.—If the date of the enactment of the Consolidated Appropriations Act, 2008 [Dec. 26, 2007], occurs on or after the date described in clause (i), the amendments made by subparagraph (A) shall be deemed to be made on the day after the effective date of sections 225(c)(1) [121 Stat. 2190] and 524 [amending this section] of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).''

EFFECTIVE DATE OF 2006 AMENDMENT

Amendment by section 5112(c) of Pub. L. 109–171 applicable to services furnished on or after Jan. 1, 2007, see section 5112(f) of Pub. L. 109–171, set out as a note under section 1395*l* of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title VI, §601(b)(2), Dec. 8, 2003, 117 Stat. 2301, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to computations of the sustainable growth rate for years beginning with 2003.''

Pub. L. 108–173, title VI, §611(e), Dec. 8, 2003, 117 Stat. 2304, provided that: ''The amendments made by this section [amending this section and sections 1395x and 1395y of this title] shall apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B [probably means part B of title XVIII of the Social Security Act, 42 U.S.C. 1395j et seq.] begins on or after such date.''

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 applicable with respect to screening mammographies furnished on or after Jan. 1, 2002, see section 1(a)(6) [title I, §104(c)] of Pub. L. 106–554, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(d)], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that: ''The amendments made by this section [amending this section and sections 1395b–6 and 1395*l* of this title] shall be effective in determining the conversion factor under section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) for years beginning with 2001 and shall not apply to or affect any update (or any update adjustment factor) for any year before 2001.''

Amendment by section 1000(a)(6) [title III, §321(k)(5)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, §321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4022(b)(2)(B), (C) of Pub. L. 105–33 effective Nov. 1, 1997, the date of termination of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, see section 4022(c)(2) of Pub. L. 105–33 set out as an Effective Date; Transition; Transfer of Functions note under section 1395b–6 of this title.

Amendment by section 4102(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4102(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4103(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 2000, see section 4103(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4104(d) of Pub. L. 105–33 applicable to items and services furnished on or after Jan. 1, 1998, see section 4104(e) of Pub. L. 105–33, set out as a note under section 1395*l* of this title.

Amendment by section 4105(a)(2) of Pub. L. 105–33 applicable to items and services furnished on or after July 1, 1998, see section 4105(d)(1) of Pub. L. 105–33, set out as a note under section 1395m of this title.

Amendment by section 4106(b) of Pub. L. 105–33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Pub. L. 105–33, title IV, §4502(a)(2), Aug. 5, 1997, 111 Stat. 433, provided that: ''The amendment made by this subsection [amending this section] shall apply to the update for years beginning with 1999.''

Pub. L. 105–33, title IV, §4504(b), Aug. 5, 1997, 111 Stat. 435, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to servics furnished on or after January 1, 1998.''

Amendment by section 4714(b)(2) of Pub. L. 105–33 applicable to payment for (and with respect to provider agreements with respect to) items and services furnished on or after Aug. 5, 1997, see section 4714(c) of Pub. L. 105–33, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 123(a) of Pub. L. 103–432 applicable to services furnished on or after Oct. 31, 1994, but inapplicable to services of nonparticipating supplier or other person furnished before Jan. 1, 1995, see section 123(f)(1) of Pub. L. 103–432, set out as a note under section 1395*l* of this title.

Pub. L. 103–432, title I, §123(f)(5), Oct. 31, 1994, 108 Stat. 4413, provided that: ''The amendment made by subsection (d) [amending this section] shall apply to reports for years beginning with 1995.''

Amendment by section 126(b)(6), (g)(2)(B), (5)–(7), (10)(A) of Pub. L. 103–432 effective as if included in the enactment of Pub. L. 101–508, see section 126(i) of Pub. L. 103–432, set out as a note under section 1395m of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13511(b), Aug. 10, 1993, 107 Stat. 581, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after January 1, 1994; except that amendment made by subsection (a)(2) shall not apply—

''(1) to volume performance standard rates of increase established under section 1848(f) of the Social Security Act [42 U.S.C. 1395w–4(f)] for fiscal years before fiscal year 1994, and

''(2) to adjustment in updates in the conversion factors for physicians' services under section 1848(d)(3)(B) of such Act for physicians' services to be furnished in calendar years before 1996.''

Pub. L. 103–66, title XIII, §13514(d), Aug. 10, 1993, 107 Stat. 583, provided that: ''The amendments made by this section [amending this section] shall apply to servics furnished on or after January 1, 1994.''

Amendment by section 13515(a)(1) of Pub. L. 103–66 applicable to services furnished on or after Jan. 1, 1994, see section 13515(d) of Pub. L. 103–66, set out as a note under section 1395u of this title.

Pub. L. 103–66, title XIII, § 13517(c), Aug. 10, 1993, 107 Stat. 586, provided that: ''The amendments made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1994.''

Pub. L. 103–66, title XIII, § 13518(c), Aug. 10, 1993, 107 Stat. 586, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1995.''

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4102(b), (g)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4102(i)(1) of Pub. L. 101–508, set out as a note under section 1395m of this title.

Amendment by section 4104(b)(2) of Pub. L. 101–508 applicable to services furnished on or after Jan. 1, 1991, see section 4104(d) of Pub. L. 101–508, set out as a note under section 1395*l* of this title.

Amendment by section 4106(b)(1) of Pub. L. 101–508 applicable to services furnished after 1991, see section 4106(d)(2) of Pub. L. 101–508, set out as a note under section 1395u of this title.

Pub. L. 101–508, title IV, § 4107(a)(2), Nov. 5, 1990, 104 Stat. 1388–62, as amended by Pub. L. 103–432, title I, § 126(d)(2), Oct. 31, 1994, 108 Stat. 4415, provided that: ''Section 1848(i)(2) of the Social Security Act [42 U.S.C. 1395w–4(i)(2)], as added by the amendment made by paragraph (1), shall apply to services furnished in 1991 in the same manner as it applies to services furnished after 1991. In applying the previous sentence, the prevailing charge shall be substituted for the fee schedule amount. In applying section 1848(g)(2)(D) of the Social Security Act for services of an assistant-at-surgery furnished during 1991, the recognized payment amount shall not exceed the maximum amount specified under section 1848(i)(2)(A) of such Act (as applied under this paragraph in such year).''

Pub. L. 101–508, title IV, § 4107(c), Nov. 5, 1990, 104 Stat. 1388–63, as amended by Pub. L. 103–432, title I, § 126(d)(1), Oct. 31, 1994, 108 Stat. 4415, provided that: ''The amendment made by subsection (a)(1) [amending this section] shall apply with respect to services furnished on or after January 1, 1992.''

Pub. L. 101–508, title IV, § 4109(b), Nov. 5, 1990, 104 Stat. 1388–63, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 1992. In applying section 1848(d)(1)(B) of the Social Security Act [42 U.S.C. 1395w–4(d)(1)(B)] (in computing the initial budget-neutral conversion factor for 1991), the Secretary shall compute such factor assuming that section 1848(b)(3) of such Act (as added by the amendment made by subsection (a)) had applied to physicians' services furnished during 1991.''

TRANSFER OF FUNCTIONS

Physician Payment Review Commission (PPRC) was terminated and its assets and staff transferred to the Medicare Payment Advisory Commission (MedPAC) by section 4022(c)(2), (3) of Pub. L. 105–33, set out as a note under section 1395b–6 of this title. Section 4022(c)(2), (3) further provided that MedPAC was to be responsible for preparation and submission of reports required by law to be submitted by PPRC, and that, for that purpose, any reference in law to PPRC was to be deemed, after the appointment of MedPAC, to refer to MedPAC.

TERMINATION OF REPORTING REQUIREMENTS

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 8 on page 94 identifies a reporting provision which, as subsequently amended, is contained in subsec. (g)(6)(B) of this section and in which item 9 on page 94 identifies a reporting provision which is contained in subsec. (g)(7)(B) of this section), see section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance.

MORATORIUM ON PAYMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE OF THE ADD ON CODE FOR INHERENTLY COMPLEX EVALUATION AND MANAGEMENT VISITS

Pub. L. 116–260, div. CC, title I, § 113, Dec. 27, 2020, 134 Stat. 2947, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services may not, prior to January 1, 2024, make payment under the fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for services described by Healthcare Common Procedure Coding System (HCPCS) code G2211 (or any successor or substantially similar code), as described in section II.F. of the final rule filed by the Secretary with the Office of the Federal Register for public inspection on December 2, 2020, and entitled 'Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19'.

''(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by interim final rule, program instruction, or otherwise.''

IMPLEMENTATION

Pub. L. 114–115, § 4(c), Dec. 28, 2015, 129 Stat. 3133, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services shall implement the provisions of, and the amendments made by, subsections (a) and (b) [amending this section and section 1395ww of this title] by program instruction, such as through information on the Internet website of the Centers for Medicare & Medicaid Services.''

EDUCATION AND OUTREACH CAMPAIGN

Pub. L. 114–10, title I, § 103(b)(1), Apr. 16, 2015, 129 Stat. 132, provided that:

''(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act [42 U.S.C. 1395w–4(b)(8)], as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

''(B) REQUIREMENTS.—Such campaign shall—

''(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

''(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.''

RECOMMENDATIONS FOR ACHIEVING WIDESPREAD ELECTRONIC HEALTH RECORD (EHR) INTEROPERABILITY

Pub. L. 114–10, title I, § 106(b)(1), Apr. 16, 2015, 129 Stat. 138, provided that:

''(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2018.

''(B) DEFINITIONS.—In this paragraph:

''(i) WIDESPREAD INTEROPERABILITY.—The term 'widespread interoperability' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

''(ii) INTEROPERABILITY.—The term 'interoperability' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

''(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2016, and in consultation with stakeholders, the Secretary [of Health and Human Services] shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

''(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2018, then the Secretary shall submit to Congress a report, by not later than December 31, 2019, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

''(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

''(ii) for criteria for decertifying certified EHR technology products.''

[As used in section 106(b)(1) of Pub. L. 114–10, set out above, ''certified EHR technology'' has the meaning given in 42 U.S.C. 1395w–4(*o*)(4); ''meaningful EHR user'' has the meaning given under the ''Medicare EHR incentive programs'', which term means the incentive programs under 42 U.S.C. 1395f(*l*)(3), 42 U.S.C. 1395w–4(*o*), 42 U.S.C. 1395w–23(*l*), (m), and 42 U.S.C. 1395ww(n); and ''Medicaid EHR incentive program'' means the incentive program under 42 U.S.C. 1396b(a)(3)(F), (t). See Pub. L. 114–10, title I, § 106(b)(4), Apr. 16, 2015, 129 Stat. 140.]

DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY

Pub. L. 113–93, title II, § 220(i), Apr. 1, 2014, 128 Stat. 1076, which required the Secretary of Health and Human Services to make publicly available information used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register on Nov. 16, 2012, was repealed by Pub. L. 114–113, div. O, title V, § 502(a)(2)(C), Dec. 18, 2015, 129 Stat. 3019.

CENTERS FOR MEDICARE & MEDICAID SERVICES TO STUDY REFORM OF PHYSICIAN REIMBURSEMENTS

Pub. L. 113–67, div. B, § 1002, Dec. 26, 2013, 127 Stat. 1195, provided that: ''In order to support the provision of quality care for our nation's seniors, Congress finds it appropriate to reform physician reimbursements under the Medicare program. SGR reform legislation provides such an opportunity, but not until next year. In order to facilitate such reform, Congress finds that the Centers for Medicare & Medicaid Services should continue to focus its efforts on the following areas:

''(1) SIMPLIFY AND REDUCE ADMINISTRATIVE BURDEN ON PHYSICIANS.—The application and assessment of measures and other activities under SGR reform should be facilitated by the Centers for Medicare and Medicaid Services (CMS) in a way that accounts for the administrative burden such measurement places on physicians. Therefore, the Congress encourages CMS to identify and implement, to the extent practicable, mechanisms to ensure that the application and assessment of measures be coordinated across programs.

''(2) TIMELY FEEDBACK FOR PHYSICIANS.—In order for measure and assessment programs to encourage the highest quality care for Medicare seniors, the Congress finds it critical that CMS provide physicians with feedback on performance in as close to real time as possible. Such timely feedback will ensure that physicians can excel under a system of meaningful measurement.

''(3) ENCOURAGE DEVELOPMENT OF NEW MODELS.—There is great need to test alternatives to Fee-For-Service reimbursement in the Medicare program. One option is the promotion and adoption of new models of care for physicians. To date, there has been significant development and testing of models for primary care. Congress supports these efforts and encourages them to continue in the future. Congress also encourages the development and testing of models of specialty care.''

IMPLEMENTATION OF 2010 AMENDMENT

Pub. L. 111–157, § 5(c), Apr. 15, 2010, 124 Stat. 1118, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section and section 1396b of this title and enacting provisions set out as a note under this section] by program instruction or otherwise.''

Pub. L. 111–148, title III, § 3111(a)(2), Mar. 23, 2010, 124 Stat. 421, provided that: ''Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) [amending this section] by program instruction or otherwise.''

Pub. L. 111–148, title III, § 3134(b)(1), Mar. 23, 2010, 124 Stat. 435, provided that:

''(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section [amending this section and section 1395ee of this title and repealing provisions set out as a note under this section] or the amendment made by this section.

''(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of [section] 1848(c)(2) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)(K), (L)], as added by subsection (a), by program instruction or otherwise.

''(C) [Repealed section 4505(d) of Pub. L. 105–33, formerly set out below.]

''(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.''

AUTHORITY TO INCORPORATE MAINTENANCE OF CERTIFICATION PROGRAMS INTO MEASURES OF QUALITY OF CARE

Pub. L. 111–148, title III, § 3002(c)(3), as added by Pub. L. 111–148, title X, § 10327(b), Mar. 23, 2010, 124 Stat. 963, provided that: ''For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).''

NO CHANGE IN BILLING

Pub. L. 110–275, title I, §131(b)(4)(B), July 15, 2008, 122 Stat. 2525, provided that: ''Nothing in the amendment made by subparagraph (A) [amending this section] shall be construed to change the way in which billing for audiology services (as defined in section 1861(*ll*)(2) of the Social Security Act (42 U.S.C. 1395x(*ll*)(2))) occurs under title XVIII of such Act [42 U.S.C. 1395 et seq.] as of July 1, 2008.''

NO EFFECT ON INCENTIVE PAYMENTS FOR 2007 OR 2008

Pub. L. 110–275, title I, §131(b)(6), July 15, 2008, 122 Stat. 2526, provided that: ''Nothing in the amendments made by this subsection or section 132 [amending this section] shall affect the operation of the provisions of section 1848(m) of the Social Security Act [42 U.S.C. 1395w–4(m)], as redesignated and amended by such subsection and section, with respect to 2007 or 2008.''

ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES

Pub. L. 110–275, title I, §138, July 15, 2008, 122 Stat. 2541, as amended by Pub. L. 111–148, title III, §3107, Mar. 23, 2010, 124 Stat. 418; Pub. L. 111–309, title I, §107, Dec. 15, 2010, 124 Stat. 3288; Pub. L. 112–78, title III, §307, Dec. 23, 2011, 125 Stat. 1285, provided that:

''(a) PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) during the period beginning on July 1, 2008, and ending on February 29, 2012, the Secretary of Health and Human Services shall increase the fee schedule otherwise applicable for specified services by 5 percent.

''(2) NONAPPLICATION OF BUDGET-NEUTRALITY.—The budget-neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply to the adjustments described in paragraph (1).

''(b) DEFINITION OF SPECIFIED SERVICES.—In this section, the term 'specified services' means procedure codes for services in the categories of the Health Care Common Procedure Coding System, established by the Secretary of Health and Human Services under section 1848(c)(5) of the Social Security Act (42 U.S.C. 1395w–4(c)(5)), as of July 1, 2007, and as subsequently modified by the Secretary, consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings, but only with respect to such services in such categories that are in the subcategories of services which are—

''(1) insight oriented, behavior modifying, or supportive psychotherapy; or

''(2) interactive psychotherapy.

''(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.''

TRANSFER OF FUNDS TO PART B TRUST FUND

Pub. L. 110–173, title I, §101(a)(2)(C), Dec. 29, 2007, 121 Stat. 2494, provided that: ''Amounts that would have been available to the Physician Assistance and Quality Initiative Fund under section 1848(*l*)(2) of the Social Security Act (42 U.S.C. 1395w–4(*l*)(2)) for payment with respect to physicians' services furnished prior to January 1, 2013, but for the amendments made by subparagraph (A) [amending this section], shall be deposited into, and made available for expenditures from, the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).''

TRANSITIONAL BONUS INCENTIVE PAYMENTS FOR QUALITY REPORTING IN 2007 AND 2008

Pub. L. 109–432, div. B, title I, §101(c), Dec. 20, 2006, 120 Stat. 2977, as amended, formerly set out as a note under this section, was transferred to subsec. (m) of this section.

TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL

Pub. L. 108–173, title III, §303(a)(2), Dec. 8, 2003, 117 Stat. 2236, provided that: ''The Secretary [of Health and Human Services] shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments made by paragraph (1) [amending this section].''

PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE

Pub. L. 108–173, title III, §303(a)(3), Dec. 8, 2003, 117 Stat. 2236, provided that:

''(A) REVIEW OF POLICY.—The Secretary [of Health and Human Services] shall review the policy, as in effect on October 1, 2003, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 drug or biological to an individual on a single day through the push technique.

''(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy as the Secretary determines to be appropriate.

''(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).''

TRANSITIONAL ADJUSTMENT

Pub. L. 108–173, title III, §303(a)(4), Dec. 8, 2003, 117 Stat. 2237, provided that:

''(A) IN GENERAL.—In order to provide for a transition during 2004 and 2005 to the payment system established under the amendments made by this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395*l*, 1395u, 1395x, 1395y, and 1396r–8 of this title, and repealing provisions set out as a note under section 1395u of this title], in the case of physicians' services consisting of drug administration services described in subparagraph (H)(iv) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), furnished on or after January 1, 2004, and before January 1, 2006, in addition to the amount determined under the fee schedule under section 1848(b) of such Act (42 U.S.C. 1395w–4(b)) there also shall be paid to the physician from the Federal Supplementary Medical Insurance Trust Fund an amount equal to the applicable percentage specified in subparagraph (B) of such fee schedule amount for the services so determined.

''(B) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for services furnished—

''(i) during 2004, is 32 percent; and

''(ii) during 2005, is 3 percent.''

MEDPAC REVIEW AND REPORTS; SECRETARIAL RESPONSE

Pub. L. 108–173, title III, §303(a)(5), Dec. 8, 2003, 117 Stat. 2237, provided that:

''(A) REVIEW.—The Medicare Payment Advisory Commission shall review the payment changes made under this section [enacting sections 1395w–3a and 1395w–3b of this title, amending this section and sections 1395*l*, 1395u, 1395x, 1395y, and 1396r–8 of this title, enacting provisions set out as notes under this section and sections 1395u, 1395w–3a, and 1395w–3b of this title, and repealing provisions set out as a note under section 1395u of this title] insofar as they affect payment under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.]—

''(i) for items and services furnished by oncologists; and

''(ii) for drug administration services furnished by other specialists.

''(B) OTHER MATTERS STUDIED.—In conducting the review under subparagraph (A), the Commission shall also review such changes as they affect—

''(i) the quality of care furnished to individuals enrolled under part B and the satisfaction of such individuals with that care;

''(ii) the adequacy of reimbursement as applied in, and the availability in, different geographic areas and to different physician practice sizes; and

''(iii) the impact on physician practices.

''(C) REPORTS.—The Commission shall submit to the Secretary [of Health and Human Services] and Congress—

''(i) not later than January 1, 2006, a report on the review conducted under subparagraph (A)(i); and

''(ii) not later than January 1, 2007, a report on the review conducted under subparagraph (A)(ii).

Each such report may include such recommendations regarding further adjustments in such payments as the Commission deems appropriate.

''(D) SECRETARIAL RESPONSE.—As part of the rulemaking with respect to payment for physicians services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for 2007, the Secretary may make appropriate adjustments to payment for items and services described in subparagraph (A)(i), taking into account the report submitted under such subparagraph (C)(i).''

MULTIPLE CHEMOTHERAPY AGENTS, OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL, AND TRANSITIONAL ADJUSTMENT

Pub. L. 108–173, title III, § 303(g)(3), Dec. 8, 2003, 117 Stat. 2253, provided that: ''There shall be no administrative or judicial review under section 1869 [probably means section 1869 of the Social Security Act, 42 U.S.C. 1395ff], section 1878 [probably means section 1878 of the Social Security Act, 42 U.S.C. 1395*oo*], or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) through (4) of subsection (a) [enacting provisions set out as notes under this section].''

APPLICATION OF 2003 AMENDMENT TO PHYSICIAN SPECIALTIES

Amendment by section 303 of Pub. L. 108–173, insofar as applicable to payments for drugs or biologicals and drug administration services furnished by physicians, is applicable only to physicians in the specialties of hematology, hematology/oncology, and medical oncology under this subchapter, see section 303(j) of Pub. L. 108–173, set out as a note under section 1395u of this title.

Notwithstanding section 303(j) of Pub. L. 108–173 (see note above), amendment by section 303 of Pub. L. 108–173 also applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology, see section 304 of Pub. L. 108–173, set out as a note under section 1395u of this title.

GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES

Pub. L. 108–173, title IV, § 413(c), Dec. 8, 2003, 117 Stat. 2277, provided that:

''(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

''(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

''(B) an evaluation of the measures used for such adjustment, including the frequency of revisions;

''(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component; and

''(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(e)(1)(E) of the Social Security Act [42 U.S.C. 1395w–4(e)(1)(E)], as added by section 412, on physician location and retention in areas affected by such adjustment, taking into account—

''(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

''(ii) the mobility of physicians, including specialists, over the last decade.

''(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).''

AMENDMENTS NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION

Pub. L. 109–171, title V, § 5104(b), Feb. 8, 2006, 120 Stat. 41, provided that: ''The amendments made by subsection (a) [amending this section] shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).''

Pub. L. 108–173, title VI, § 601(a)(3), Dec. 8, 2003, 117 Stat. 2301, provided that: ''The amendments made by this subsection [amending this section] shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).''

COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT DATA

Pub. L. 108–173, title VI, § 605, Dec. 8, 2003, 117 Stat. 2302, provided that:

''(a) IN GENERAL.—Not later than January 1, 2005, the Secretary [of Health and Human Services] shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate persons, review and consider alternative data sources than those currently used in establishing the geographic index for the practice expense component under the medicare physician fee schedule under section 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(i)).

''(b) SITES.—The Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

''(c) REPORT AND RECOMMENDATIONS.—

''(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the

review and consideration conducted under subsection (a). Such report shall include information on the alternative developed data sources considered by the Secretary under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index, and the estimated impacts of using such alternative data.

''(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations on which data sources reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the medicare physician fee schedule.''

MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES

Pub. L. 108–173, title VI, §606, Dec. 8, 2003, 117 Stat. 2302, provided that:

''(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

''(1) The effect of such refinements on payment for physicians' services.

''(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

''(3) The appropriateness of the amount of compensation by reason of such refinements.

''(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

''(5) The effect of such refinements on physician participation under the medicare program.

''(b) VOLUME OF PHYSICIANS' SERVICES.—Not later than 1 year after the date of the enactment of this Act [Dec. 8, 2003], the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B [42 U.S.C. 1395j et seq.] of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

''(1) An analysis of recent and historic growth in the components that the Secretary [of Health and Human Services] includes under the sustainable growth rate (under section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f))).

''(2) An examination of the relative growth of volume in physicians' services between medicare beneficiaries and other populations.

''(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

''(4) An examination of the impact on volume of demographic changes.

''(5) An examination of shifts in the site of service or services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have effected these changes.

''(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.''

MEDPAC STUDY OF PAYMENT FOR CARDIO-THORACIC SURGEONS

Pub. L. 108–173, title VI, §644, Dec. 8, 2003, 117 Stat. 2323, provided that:

''(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the 'Commission') shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

''(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.''

REPORT ON PHYSICIAN COMPENSATION

Pub. L. 108–173, title IX, §953(a)(2), Dec. 8, 2003, 117 Stat. 2428, provided that: ''Not later than 12 months after the date of the enactment of this Act [Dec. 8, 2003], the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).''

TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE

Pub. L. 106–554, §1(a)(6) [title V, §542], Dec. 21, 2000, 114 Stat. 2763, 2763A–550, as amended by Pub. L. 108–173, title VII, §732, Dec. 8, 2003, 117 Stat. 2352; Pub. L. 109–432, div. B, title I, §104, Dec. 20, 2006, 120 Stat. 2981; Pub. L. 110–173, title I, §104, Dec. 29, 2007, 121 Stat. 2495; Pub. L. 110–275, title I, §136, July 15, 2008, 122 Stat. 2540; Pub. L. 111–148, title III, §3104, Mar. 23, 2010, 124 Stat. 417; Pub. L. 111–309, title I, §105, Dec. 15, 2010, 124 Stat. 3287; Pub. L. 112–78, title III, §305, Dec. 23, 2011, 125 Stat. 1284; Pub. L. 112–96, title III, §3006, Feb. 22, 2012, 126 Stat. 189, provided that:

''(a) IN GENERAL.—When an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary of Health and Human Services shall treat such component as a service for which payment shall be made to the laboratory under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) or as an outpatient hospital service for which payment is made to the hospital under section 1833(t) of such Act (42 U.S.C. 1395*l*(t)).

''(b) DEFINITIONS.—For purposes of this section:

''(1) COVERED HOSPITAL.—The term 'covered hospital' means, with respect to an inpatient or an outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a medicare carrier (that has a contract with the Secretary under section 1842 of the Social Security Act, 42 U.S.C. 1395u) and not to such hospital.

''(2) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who—

''(A) is entitled to benefits under part A, or enrolled under part B, or both, of such title [42 U.S.C. 1395c et seq., 1395j et seq.]; and

''(B) is not enrolled in any of the following:

''(i) A Medicare+Choice plan under part C of such title [42 U.S.C. 1395w–21 et seq.].

''(ii) A plan offered by an eligible organization under section 1876 of such Act (42 U.S.C. 1395mm).

''(iii) A program of all-inclusive care for the elderly (PACE) under section 1894 of such Act (42 U.S.C. 1395eee).

''(iv) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) [101 Stat. 1330–65].

''(c) EFFECTIVE DATE.—This section shall apply to services furnished during the 2-year period beginning on January 1, 2001, and for services furnished during 2005, 2006, 2007, 2008, 2009, 2010, 2011, and the first six months of 2012.

''(d) GAO REPORT.—

''(1) STUDY.—The Comptroller General of the United States shall conduct a study of the effects of the previous provisions of this section on hospitals and laboratories and access of fee-for-service medicare beneficiaries to the technical component of physician pathology services.

''(2) REPORT.—Not later than April 1, 2002, the Comptroller General shall submit to Congress a report on such study. The report shall include recommendations about whether such provisions should be extended after the end of the period specified in subsection (c) for either or both inpatient and outpatient hospital services, and whether the provisions should be extended to other hospitals.''

ONE-TIME PUBLICATION OF INFORMATION ON TRANSITION

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §211(a)(2)(C)], Nov. 29, 1999, 113 Stat. 1536, 1501A–347, provided that: ''The Secretary of Health and Human Services shall cause to have published in the Federal Register, not later than 90 days after the date of the enactment of this section [Nov. 29, 1999], the Secretary's determination, based upon the best available data, of—

''(i) the allowed expenditures under subclauses (I) and (II) of subsection (d)(4)(C)(ii) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by subsection (a)(1)(B), for the 9-month period beginning on April 1, 1999, and for 1999;

''(ii) the estimated actual expenditures described in subsection (d) of such section for 1999; and

''(iii) the sustainable growth rate under subsection (f) of such section for 2000.''

USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINING PRACTICE EXPENSE RELATIVE VALUES

Pub. L. 106–113, div. B, §1000(a)(6) [title II, §212], Nov. 29, 1999, 113 Stat. 1536, 1501A–350, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation (after notice and opportunity for public comment) a process (including data collection standards) under which the Secretary will accept for use and will use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations (other than the Department of Health and Human Services) to supplement the data normally collected by that Department in determining the practice expense component under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)) for purposes of determining relative values for payment for physicians' services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4). The Secretary shall first promulgate such regulation on an interim final basis in a manner that permits the submission and use of data in the computation of practice expense relative value units for payment rates for 2001.

''(b) PUBLICATION OF INFORMATION.—The Secretary shall include, in the publication of the estimated and final updates under section 1848(c) of such Act (42 U.S.C. 1395w–4(c)) for payments for 2001 and for 2002, a description of the process established under subsection (a) for the use of external data in making adjustments in relative value units and the extent to which the Secretary has used such external data in making such adjustments for each such year, particularly in cases in which the data otherwise used are inadequate because such data are not based upon a large enough sample size to be statistically reliable.''

CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS

Pub. L. 105–33, title IV, §4105(a)(3), Aug. 5, 1997, 111 Stat. 367, provided that: ''In establishing payment amounts under section 1848 of the Social Security Act [42 U.S.C. 1395w–4] for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes.''

DEVELOPMENT OF RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS

Pub. L. 105–33, title IV, §4505(d), Aug. 5, 1997, 111 Stat. 435, which required the Secretary of Health and Human Services to develop new resource-based relative value units in accordance with certain procedures, transmit a report by Mar. 1, 1998, to certain Congressional Committees, publish a notice of proposed rulemaking with the new relative value units on or before May 1, 1998, and allow public comment, was repealed by Pub. L. 111–148, title III, §3134(b)(1)(C), Mar. 23, 2010, 124 Stat. 435.

APPLICATION OF CERTAIN BUDGET NEUTRALITY PROVISIONS

Pub. L. 105–33, title IV, §4505(f)(2), Aug. 5, 1997, 111 Stat. 437, provided that: ''In implementing the amendment made by paragraph (1)(A)(ii) [amending this section], the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.''

DEVELOPMENT OF RESOURCE-BASED METHODOLOGY FOR PRACTICE EXPENSES

Pub. L. 103–432, title I, §121(a), Oct. 31, 1994, 108 Stat. 4408, provided that:

''(1) IN GENERAL.—The Secretary of Health and Human Services shall develop a methodology for implementing in 1998 a resource-based system for determining practice expense relative value units for each physicians' service. The methodology utilized shall recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.

''(2) REPORT.—The Secretary shall transmit a report by June 30, 1996, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data utilized in developing the methodology and an explanation of the methodology.''

APPLICATION OF SUBSECTION (c)(2)(B)(ii)(II), (iii)

Pub. L. 103–432, title I, §121(b)(3), Oct. 31, 1994, 108 Stat. 4409, provided that: ''In implementing the amendment made by paragraph (1)(C) [amending this section], the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act [42 U.S.C. 1395w–4(c)(2)(B)(ii)(II), (iii)] shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.''

REPORT ON REVIEW PROCESS

Pub. L. 103–432, title I, §122(c), Oct. 31, 1994, 108 Stat. 4409, provided that not later than 1 year after Oct. 31,

1994, Secretary of Health and Human Services was to study and report to Congress on data necessary to review and revise indices established under subsec. (e)(1)(A) of this section, any limitations on availability of data necessary to review and revise such indices at least every three years, ways of addressing such limitations, with particular attention to the development of alternative data sources for input components for which current index values are based on data collected less frequently than every three years, and costs of developing more accurate and timely data.

RELATIVE VALUE FOR PEDIATRIC SERVICES

Pub. L. 103–432, title I, §124(a), Oct. 31, 1994, 108 Stat. 4413, provided that: ''The Secretary of Health and Human Services shall fully develop, by not later than July 1, 1995, relative values for the full range of pediatric physicians' services which are consistent with the relative values developed for other physicians' services under section 1848(c) of the Social Security Act [42 U.S.C. 1395w–4(c)]. In developing such values, the Secretary shall conduct such refinements as may be necessary to produce appropriate estimates for such relative values.''

BUDGET NEUTRALITY ADJUSTMENT

For provisions requiring reduction of relative values established under subsec. (c) of this section and amounts determined under subsec. (a)(2)(B)(ii)(I) of this section for 1994 (to be applied for that year and subsequent years) in order to assure that the amendments to this section and section 1395u of this title by section 13515(a) of Pub. L. 103–66 will not result in expenditures under this part that exceed the amount of such expenditures that would have been made if such amendments had not been made, see section 13515(b) of Pub. L. 103–66, set out as a note under section 1395u of this title.

Pub. L. 103–66, title XIII, §13518(b), Aug. 10, 1993, 107 Stat. 586, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services shall implement the amendment made by subsection (a) [amending this section] in a manner to assure that such amendment will result in expenditures under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] in 1995 for services described in such amendment that shall be equal to the amount of expenditures for such services that would have been made if such amendment had not been made.''

ANCILLARY POLICIES; ADJUSTMENT FOR INDEPENDENT LABORATORIES FURNISHING PHYSICIAN PATHOLOGY SERVICES

Pub. L. 101–508, title IV, §4104(c), Nov. 5, 1990, 104 Stat. 1388–59, provided that: ''The Secretary of Health and Human Services, in establishing ancillary policies under section 1848(c)(3) of the Social Security Act [42 U.S.C. 1395w–4(c)(3)], shall consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from an attending or consulting physician's office.''

COMPUTATION OF CONVERSION FACTOR FOR 1992

Pub. L. 101–508, title IV, §4105(b)(2), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(A)(i), Oct. 31, 1994, 108 Stat. 4415, provided that: ''In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act for 1992 [42 U.S.C. 1395w–4(d)(1)(B)], the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B of title XVIII of such Act [42 U.S.C. 1395j et seq.] for physicians' services in 1991 assuming that the amendment made by this subsection [amending section 1395u of this title] did not apply.''

Pub. L. 101–508, title IV, §4106(c), Nov. 5, 1990, 104 Stat. 1388–62, as amended by Pub. L. 103–432, title I, §126(g)(3), Oct. 31, 1994, 108 Stat. 4416, provided that: ''In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act [42 U.S.C. 1395w–4(d)(1)(B)] for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B [42 U.S.C. 1395j et seq.] for physicians' services in 1991 assuming that the amendments made by this section [amending this section, section 1395u of this title, and provisions set out as a note under section 1395u of this title] (notwithstanding subsection (d) [set out as an Effective Date of 1990 Amendment note under section 1395u of this title]) applied to all services furnished during such year.''

PUBLICATION OF PERFORMANCE STANDARD RATES

Pub. L. 101–508, title IV, §4105(d), Nov. 5, 1990, 104 Stat. 1388–60, as amended by Pub. L. 103–432, title I, §126(g)(2)(C), Oct. 31, 1994, 108 Stat. 4416, provided that: ''Not later than 45 days after the date of the enactment of this Act [Nov. 5, 1990], the Secretary of Health and Human Services, based on the most recent data available, shall estimate and publish in the Federal Register the performance standard rates of increase specified in section 1848(f)(2)(C) of the Social Security Act [42 U.S.C. 1395w–4(f)(2)(C)] for fiscal year 1991.''

STUDY OF REGIONAL VARIATIONS IN IMPACT OF MEDICARE PHYSICIAN PAYMENT REFORM

Pub. L. 101–508, title IV, §4115, Nov. 5, 1990, 104 Stat. 1388–65, provided that:

''(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

''(1) factors that may explain geographic variations in Medicare reasonable charges for physicians' services that are not attributable to variations in physician practice costs (including the supply of physicians in an area and area variations in the mix of services furnished);

''(2) the extent to which the geographic practice cost indices applied under the fee schedule established under section 1848 of the Social Security Act [42 U.S.C. 1395w–4] accurately reflect variations in practice costs and malpractice costs (and alternative sources of information upon which to base such indices);

''(3) the impact of the transition to a national, resource-based fee schedule for physicians' services under Medicare on access to physicians' services in areas that experience a disproportionately large reduction in payments for physicians' services under the fee schedule by reason of such variations; and

''(4) appropriate adjustments or modifications in the transition to, or manner of determining payments under, the fee schedule established under section 1848 of the Social Security Act, to compensate for such variations and ensure continued access to physicians' services for Medicare beneficiaries in such areas.

''(b) REPORT.—By not later than July 1, 1992, the Secretary shall submit to Congress a report on the study conducted under subsection (a).''

STATEWIDE FEE SCHEDULE AREAS FOR PHYSICIANS' SERVICES

Pub. L. 101–508, title IV, §4117, Nov. 5, 1990, 104 Stat. 1388–65, as amended by Pub. L. 103–432, title I, §126(f), Oct. 31, 1994, 108 Stat. 4415, provided that: ''Notwithstanding section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)), in the case of the States of Nebraska and Oklahoma the Secretary of Health and Human Services (Secretary) shall treat the State as a single fee schedule area for purposes of determining—

''(1) the adjusted historical payment basis (as defined in section 1848(a)(2)(D) of such Act (42 U.S.C. 1395w–4(a)(2)(D))), and

''(2) the fee schedule amount (as referred to in section 1848(a) (42 U.S.C. 1395w–4(a)) of such Act),

for physicians' services (as defined in section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3))) furnished on or after January 1, 1992.''

STUDIES

Pub. L. 101–239, title VI, § 6102(d), Dec. 19, 1989, 103 Stat. 2185, as amended by Pub. L. 103–432, title I, § 126(h)(1), Oct. 31, 1994, 108 Stat. 4416; Pub. L. 105–362, title VI, § 601(b)(5), Nov. 10, 1998, 112 Stat. 3286, provided for various studies and reports as follows: (1) directed Comptroller General to conduct study of alternative payment methodology for malpractice component for physicians' services, and to submit report to Congress by not later than Apr. 1, 1991; (2) directed Secretary of Health and Human Services to conduct study of how payments under this section may affect payments to eligible organizations with risk-sharing contracts under section 1395mm of this title, and to submit report to Congress by not later than Apr. 1, 1990; (3) directed Secretary to conduct study of volume performance standard rates of increase for services furnished by geography, specialty, and type of service, and to submit report with appropriate recommendations to Congress by not later than July 1, 1990; (4) directed Physician Payment Review Commission to conduct study of payment for practice and malpractice expenses, including appropriate methods for allocating malpractice expenses to particular procedures which could be incorporated into the determination of relative values for such procedures using a consensus panel and other appropriate methodologies, and to submit report and recommendations to Congress by not later than July 1, 1991; (5) directed Physician Payment Review Commission to conduct study of feasibility and desirability of using Metropolitan Statistical Areas or other payment areas for purposes of payment for physicians' services under this part, and to submit report to Congress by not later than July 1, 1991; (6) directed Physician Payment Review Commission to conduct study of payment for nonphysician providers of medicare services, including physician assistants, clinical psychologists, nurse midwives, and other health practitioners whose services can be billed under medicare program on a fee-for-service basis, and to submit report to Congress by not later than July 1, 1991; (7) directed Physician Payment Review Commission to conduct study of physician fees under State medicaid programs established under subchapter XIX of this chapter, and to submit report with recommendations to Congress by no later than July 1, 1991; and (8) directed Comptroller General to conduct study of effect of anti-trust laws on ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization, and to submit report to Congress by no later than July 1, 1991.

DISTRIBUTION OF MODEL FEE SCHEDULE

Pub. L. 101–239, title VI, § 6102(e)(11), Dec. 19, 1989, 103 Stat. 2188, as amended by Pub. L. 101–508, title IV, § 4118(f)(2)(E), Nov. 5, 1990, 104 Stat. 1388–70, provided that: ''By September 1, 1990, the Secretary of Health and Human Services shall develop a Model Fee Schedule, using the methodology set forth in section 1848 of the Social Security Act [42 U.S.C. 1395w–4]. The Model Fee Schedule shall include as many services as the Secretary of Health and Human Services concludes can be assigned valid relative values. The Secretary of Health and Human Services shall submit the Model Fee Schedule to the appropriate committees of Congress and make it generally available to the public.''

§ 1395w–5. Public reporting of performance information

(a) In general

(1) Development

Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

(2) Plan

Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) Other required considerations

In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and