

(ii) Limitations

The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

(3) Antidiscrimination limitation

The Secretary shall not enter into an agreement with an entity to provide health care items or services under the demonstration program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1)¹ of the Public Health Service Act.

(d) Limitations on judicial review

The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

(1) Limiting the implementation of the program under subsection (a)(2).

(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

(4) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

(5) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

(A) as to whether cost savings have been achieved, and the amount of savings; or

(B) as to whether, to whom, and in what amounts bonuses will be paid.

(e) Application limited to parts A and B

None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

(f) Reports to Congress

Not later than two years after December 21, 2000, and biennially thereafter for six years, the Secretary shall report to Congress on the use of authorities under the demonstration program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this subchapter.

(Aug. 14, 1935, ch. 531, title XVIII, §1866B, as added Pub. L. 106-554, §1(a)(6) [title IV, §412(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-511; amended Pub. L. 108-173, title VII, §736(c)(5), Dec. 8, 2003, 117 Stat. 2356.)

¹ See References in Text note below.

Editorial Notes

REFERENCES IN TEXT

Section 2702 of the Public Health Service Act, referred to in subsec. (c)(3), is section 2702 of act July 1, 1944, which was classified to section 300gg-1 of this title, was amended by Pub. L. 111-148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (d) to (f) of section 300gg-4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111-148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg-1 of this title.

CODIFICATION

In subsec. (b)(4)(B), “section 6101 of title 41” substituted for “section 5 of title 41, United States Code” on authority of Pub. L. 111-350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2003—Subsec. (b)(7)(D). Pub. L. 108-173 substituted “(c)(2)(B)” for “(c)(2)(A)(ii)”.

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.

§ 1395cc-3. Health care quality demonstration program**(a) Definitions**

In this section:

(1) Beneficiary

The term “beneficiary” means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

(2) Health care group**(A) In general**

The term “health care group” means—

(i) a group of physicians that is organized at least in part for the purpose of providing physician’s services under this subchapter;

(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

(B) Inclusion

As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrange-

ment structured so that such hospital, individual, or entity participates in a demonstration project under this section.

(3) Physician

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

(b) Demonstration projects

The Secretary shall establish a demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

- (1) the provision of incentives to improve the safety of care provided to beneficiaries;
- (2) the appropriate use of best practice guidelines by providers and services by beneficiaries;
- (3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;
- (4) encourage shared decision making between providers and patients;
- (5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;
- (6) the appropriate use of culturally and ethnically sensitive health care delivery; and
- (7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

(c) Administration by contract

(1) In general

Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1395cc-1 of this title is administered in accordance with section 1395cc-2 of this title.

(2) Alternative payment systems

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

- (A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and
- (B) streamline documentation and reporting requirements otherwise required under this subchapter.

(3) Benefits

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the origi-

nal medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient’s surrogate) on the basis of the patient’s age or expected length of life or of the patient’s present or predicted disability, degree of medical dependency, or quality of life.

(d) Eligibility criteria

To be eligible to receive assistance under this section, an entity shall—

- (1) be a health care group;
- (2) meet quality standards established by the Secretary, including—
 - (A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;
 - (B) the implementation of activities to increase the delivery of effective care to beneficiaries;
 - (C) encouraging patient participation in preference-based decisions;
 - (D) the implementation of activities to encourage the coordination and integration of medical service delivery; and
 - (E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and
- (3) meet such other requirements as the Secretary may establish.

(e) Waiver authority

The Secretary may waive such requirements of this subchapter and subchapter XI as may be necessary to carry out the purposes of the demonstration program established under this section.

(f) Budget neutrality

With respect to the period of the demonstration program under subsection (b), the aggregate expenditures under this subchapter for such period shall not exceed the aggregate expenditures that would have been expended under this subchapter if the program established under this section had not been implemented.

(g) Notice requirements

In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this subchapter as a result of the participation of the individual in such program.

(h) Participation and support by Federal agencies

In carrying out the demonstration program under this section, the Secretary may direct—

(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

(Aug. 14, 1935, ch. 531, title XVIII, §1866C, as added Pub. L. 108-173, title VI, §646, Dec. 8, 2003, 117 Stat. 2324; amended Pub. L. 111-148, title III, §3021(c), Mar. 23, 2010, 124 Stat. 395.)

Editorial Notes

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (h)(3), is Pub. L. 104-191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see section 1(a) of Pub. L. 104-191, set out as a Short Title of 1996 Amendments note under section 201 of this title and Tables.

AMENDMENTS

2010—Subsec. (b). Pub. L. 111-148 struck out “5-year” before “demonstration program” in introductory provisions.

Subsec. (f). Pub. L. 111-148 struck out “5-year” before “period of the demonstration program”.

§ 1395cc-4. National pilot program on payment bundling

(a) Implementation

(1) In general

The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this subchapter.

(2) Definitions

In this section:

(A) Applicable beneficiary

The term “applicable beneficiary” means an individual who—

- (i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such subchapter, but not enrolled under part C or a PACE program under section 1395eee of this title; and
- (ii) is admitted to a hospital for an applicable condition.

(B) Applicable condition

The term “applicable condition” means 1 or more of 10 conditions selected by the Sec-

retary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

(i) Whether the conditions selected include a mix of chronic and acute conditions.

(ii) Whether the conditions selected include a mix of surgical and medical conditions.

(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this subchapter.

(iv) Whether a condition has significant variation in—

(I) the number of readmissions; and

(II) the amount of expenditures for post-acute care spending under this subchapter.

(v) Whether a condition is high-volume and has high post-acute care expenditures under this subchapter.

(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this subchapter.

(C) Applicable services

The term “applicable services” means the following:

(i) Acute care inpatient services.

(ii) Physicians’ services delivered in and outside of an acute care hospital setting.

(iii) Outpatient hospital services, including emergency department services.

(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

(v) Other services the Secretary determines appropriate.

(D) Episode of care

(i) In general

Subject to clause (ii), the term “episode of care” means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

(II) the length of stay of the applicable beneficiary in such hospital; and

(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

(ii) Establishment of period by the Secretary

The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

(E) Physicians’ services

The term “physicians’ services” has the meaning given such term in section 1395x(q) of this title.

(F) Pilot program

The term “pilot program” means the pilot program under this section.