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116TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPT. 116–327
Part 1

MEDICARE VISION ACT OF 2019

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ON

H.R. 4665

together with

ADDITIONAL VIEWS

DECEMBER 6, 2019.—Ordered to be printed

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CONTENTS

	Page
I. SUMMARY AND BACKGROUND	3
A. Purpose and Summary	3
B. Background and Need for Legislation	3
C. Legislative History	4
II. EXPLANATION OF THE BILL	5
A. The Medicare Vision Act of 2019	5
III. VOTES OF THE COMMITTEE	7
IV. BUDGET EFFECTS OF THE BILL	8
A. Committee Estimate of Budgetary Effects	8
B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority	8
C. Cost Estimate Prepared by the Congressional Budget Office	8
V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE	8
A. Committee Oversight Findings and Recommendations	8
B. Statement of General Performance Goals and Objectives	8
C. Information Relating to Unfunded Mandates	9
D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits	9
E. Duplication of Federal Programs	9
F. Hearings	9
VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED	9
VII. ADDITIONAL VIEWS	337

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MEDICARE VISION ACT OF 2019

DECEMBER 6, 2019.—Ordered to be printed

Mr. NEAL, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 4665]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4665) to amend title XVIII of the Social Security Act to provide coverage for certain vision items and services under part B of the Medicare program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Vision Act of 2019".

SEC. 2. PROVIDING COVERAGE FOR VISION CARE UNDER THE MEDICARE PROGRAM.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (GG), by striking "and" after the semicolon at the end;

(2) in subparagraph (HH), by striking the period at the end and adding "; and"; and

(3) by adding at the end the following new subparagraph:

"(II) vision services (as defined in subsection (kkk));".

(b) VISION SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"(kkk) VISION SERVICES.—The term 'vision services' means—

"(1) routine eye examinations to determine the refractive state of the eyes, including procedures performed during the course of such examination; and

"(2) contact lens fitting services;

furnished on or after January 1, 2022, by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such examinations, procedures, or fitting services (as applicable) under State law (or the State regulatory mechanism provided by State law) of the State in which the examinations, procedures, or fitting services are furnished.".

(c) PAYMENT; COINSURANCE; AND LIMITATIONS.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before "(CC)"; and

(B) by inserting before the semicolon at the end the following: ", and (DD) with respect to vision services (as defined in section 1861(kkk)), the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under the payment basis determined under section 1848".

(2) LIMITS SPECIFIED.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(x) LIMITATION FOR VISION SERVICES.—With respect to vision services (as defined in section 1861(kkk)) and an individual, payment may be made under this part for only 1 routine eye examination described in paragraph (1) of such section and 1 contact lens fitting service described in paragraph (2) of such section during a 2-year period.".

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—

(1) IN GENERAL.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting "(2)(II)," before "(3)".

(2) BUDGET NEUTRALITY.—Section 1848(c)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395–w(c)(2)(B)(iv)) is amended—

(A) in subclause (III), by striking "and" at the end;

(B) in subclause (IV), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following new subclause:

"(V) the amendment made by section 2(d)(1) of the Medicare Vision Act of 2019 shall not be taken into account in applying clause (ii)(II) for 2022 and 2023.".

(e) COVERAGE OF CONVENTIONAL EYEGLASSES AND CONTACT LENSES.—Section 1861(s)(8) of the Social Security Act (42 U.S.C. 1395x(s)(8)) is amended by striking ", and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens" and inserting ", including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens, if furnished before January 1, 2022, and including conventional eyeglasses or contact lenses, whether or not furnished subsequent to such a surgery, if furnished on or after January 1, 2022".

(f) SPECIAL PAYMENT RULES FOR EYEGLASSES AND CONTACT LENSES.—

(1) LIMITATIONS.—Section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) is amended by adding at the end the following new paragraph:

"(6) PAYMENT LIMITATIONS FOR EYEGLASSES AND CONTACT LENSES.—

"(A) IN GENERAL.—With respect to eyeglasses and contact lenses furnished to an individual on or after January 1, 2022, subject to subparagraph (B), payment may be made under this part only—

"(i) during a 2-year period, for either 1 pair of eyeglasses (including lenses and frames) or a 2-year supply that is provided in not more than 180-day increments of contact lenses;

"(ii) with respect to amounts attributable to the frames of such a pair of eyeglasses and amounts attributable to contact lenses furnished during a year, in an amount not greater than—

"(I) for 2022, $100; and

"(II) for a subsequent year, the amount specified under this subparagraph for the previous year, increased by the percentage change in the consumer price index for all urban consumers during such previous year;

"(iii) for types of eyeglass lenses, and for types of contact lenses, as determined appropriate by the Secretary;

"(iv) if furnished pursuant to a written order of a physician described in section 1861(kkk); and

"(v) if during the 2-year period described in clause (i), the individual did not already receive (as described in subparagraph (B)) one pair of conventional eyeglasses or contact lenses subsequent to a cataract surgery with insertion of an intraocular lens furnished during such period.

"(B) EXCEPTION.—With respect to a 2-year period described in subparagraph (A)(i), in the case of an individual who receives cataract surgery with insertion of an intraocular lens, notwithstanding subparagraph (A), payment may be made under this part for one pair of conventional eyeglasses or contact lenses furnished subsequent to such cataract surgery during such period.".

(2) APPLICATION OF COMPETITIVE ACQUISITION.—

(A) IN GENERAL.—Section 1834(h)(1)(H) of the Social Security Act (42 U.S.C. 1395m(h)(1)(H)) is amended—

(i) in the header by inserting ", EYEGLASSES, AND CONTACT LENSES" after "ORTHOTICS";

(ii) by inserting "and of eyeglasses and contact lenses described in paragraph (2)(D) of such section," after "2009," ; and

(iii) in clause (i), by inserting "or such eyeglasses and contact lenses" after "orthotics".

(B) CONFORMING AMENDMENT.—

(i) IN GENERAL.—Section 1847(a)(2) of the Social Security Act (42 U.S.C. 1395w–3(a)(2)) is amended by adding at the end the following new subparagraph:

"(D) EYEGLASSES AND CONTACT LENSES.—Eyeglasses and contact lenses for which payment would otherwise be made under section 1834(h).".

(ii) EXEMPTION OF CERTAIN ITEMS FROM COMPETITIVE ACQUISITION.—Section 1847(a)(7) of the Social Security Act (42 U.S.C. 1395w–3(a)(7)) is amended by adding at the end the following new subparagraph:

"(C) CERTAIN EYEGLASSES AND CONTACT LENSES.—Those items and services described in paragraph (2)(D) if furnished by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service.".

(g) EXCLUSION MODIFICATIONS.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (O), by striking "and" at the end;

(B) in subparagraph (P), by striking the semicolon at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(Q) in the case of vision services (as defined in section 1861(kkk)) that are routine eye examinations and contact lens fitting services (as described in paragraph (1) or (2), respectively, of such section), which are furnished more frequently than once during a 2-year period;"; and

(2) in paragraph (7)—

(A) by inserting "(other than such an examination that is a vision service that is covered under section 1861(s)(2)(II))" after "eye examinations"; and

(B) by inserting "(other than such a procedure that is a vision service that is covered under section 1861(s)(2)(II))" after "refractive state of the eyes".

SEC. 3. IMPLEMENTATION FUNDING.

The Secretary of Health and Human Services shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Services Program Management Account for the period of 2020 through 2024 of such sums as may be necessary for purposes of implementing the amendments made by section 2.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 4665, the Medicare Vision Act of 2019, as ordered reported by the Committee on Ways and Means on October 22, 2019, amends Title XVIII of the Social Security Act in order to add benefits for vision services in Medicare

B. BACKGROUND AND NEED FOR LEGISLATION

Since 1965, Medicare has excluded coverage for most vision services. This is a coverage gap that leaves Medicare beneficiaries at risk for preventable vision health issues that can result in unnecessary emergency department (ED) visits, longer term health issues, and higher Medicare spending.[1] The addition of new vision benefits

[1] Willink, A, Schoen, C, and Davis, K (2017). Consideration of Dental, Vision, and Hearing Services to be Covered Under Medicare. *JAMA, 318*(7).

to Medicare would bridge a notable gap in Medicare coverage and help millions of beneficiaries to avoid more severe health outcomes that are associated with deficits in this area.

The inclusion of vision benefits within the Medicare program has the potential to not only improve daily quality of life for Medicare beneficiaries but also reduce the risk of more serious long-term health issues.[2] An estimated 20.5 million Medicare beneficiaries have vision problems, yet only 57 percent said they had received an eye examination during the previous year, according to one survey.[3] Medicare beneficiaries who had received vision services in the previous year spent on average $715 annually, 60 percent of which was paid out-of-pocket.[4]

C. Legislative History

Background

H.R. 4665 was introduced on October 11, 2019 and was referred to the Committee on Energy and Commerce and additionally, to the Committee on Ways and Means.

Committee hearings

On October 17, 2019, the Committee on Ways and Means held a full committee hearing entitled, "Investing in the U.S. Health System by Lowering Drug Prices, Reducing Out-of-Pocket Costs, and Improving Medicare Benefits," to discuss how H.R. 3, the Lower Drug Costs Now Act, will lower prescription drug prices in Medicare and the commercial market, improve affordability of medicine, and reduce costs for patients and taxpayers. The committee also discussed ways savings from H.R. 3 can be reinvested to improve care and lower costs for seniors and people with disabilities enrolled in Medicare, including the addition of vision services.

On June 4, 2019, the Committee on Ways and Means held a full committee Member Day hearing to discuss the range of issues and proposals among on-committee and off-committee member, which included specific discussions around beneficiary improvements in Medicare.

Committee action

The Committee on Ways and Means marked up H.R. 4665, the Medicare Vision Act of 2019, on October 22, 2019, and ordered the bill, as amended, favorably reported by voice vote (with a quorum being present).

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[2] Making Eye Health a Population Health Imperative: Vision for Tomorrow. National Academy of Sciences. 2016. Available at https://www.nap.edu/catalog/23471/making-eye-health-a-population-health-imperative-vision-for-tomorrow.

[3] Willink, A, Schoen, C, and Davis, K (2017). Consideration of Dental, Vision, and Hearing Services to be Covered Under Medicare. *JAMA, 318*(7).

[4] Willink, A, Schoen, C, and Davis, K. (2018). How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries. *The Commonwealth Fund.* Available at https://www.commonwealthfund.org/publications/issue-briefs/2018/jan/how-medicare-could-provide-dental-vision-and-hearing-care.

II. EXPLANATION OF THE BILL

A. THE MEDICARE VISION ACT OF 2019

CURRENT LAW

Several criteria must be met in order for Medicare to pay for an item or service. It must be eligible for one of the defined Medicare benefit categories (e.g., hospital care, physician's services, durable medical equipment, prosthetics and orthotics, etc.); it must not be an item that is specifically, statutorily excluded from coverage (e.g., hearing aids, dentures, and, in general, eyeglasses); and as specified at Social Security Act (SSA) section 1862(a)(1)(A), and it must be "reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member." Alternatively, an item or service may be specified in statute as being covered by Medicare even if it would not otherwise meet the above criteria (e.g., preventive services).

In general, Medicare Part A[5] covers inpatient hospital stays, among other items and services, and Medicare Part B[6] covers physician services and certain prosthetic devices that are devices that replace all or part of an internal body organ. Medicare-covered prosthetics may include such items as prosthetic limbs, breasts, ostomy bags, and certain related supplies, as well as certain surgically implanted devices. Specifically, with respect to vision care, Medicare covers intraocular lenses, hospital facility and physician charges, and one pair of eyeglasses or contact lenses as part of a Medicare-covered cataract surgery. Medicare also covers eye prostheses for patients with absence or shrinkage of the eye due to birth defect, trauma, or surgical removal. Medicare also covers certain physician service and tests associated with vision care such as glaucoma screenings for beneficiaries at high risk of glaucoma, eye exams to evaluate eye disease in patients with diabetes and certain tests and treatments associated with macular degeneration. However, eye glasses (other than as part of cataract surgery) and routine eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses are statutorily excluded from Medicare coverage.

Medicare payments for prosthetic devices are determined by a variety of methods (fee schedules, adjustments to fee schedules, and competitive bidding). Except in competitive bidding areas (CBAs, described below), Medicare pays for prosthetic devices based on statutorily specified formulas or fee schedules. Medicare pays 80 percent of the lower of a supplier's charge for the item or the fee schedule amount. The beneficiary is responsible for the remaining 20 percent. In general, fee schedule amounts are updated each year by (1) measure of price inflation, and (2) a measure of economy-wide productivity. Since 2016, the fee schedule rates that applied outside of competitive bidding areas for certain items have been reduced based on price information from the competitive bidding program.

The Department of Health and Human Services (HHS) Secretary (Secretary) established a Competitive Acquisition Program for cer-

[5] Section 1812 of the Social Security Act (42 U.S.C. § 1395d).
[6] Section 1832 of the Social Security Act (42 U.S.C. § 1395k).

tain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in specified areas. Instead of paying for equipment based on a fee schedule established by law, payment for items in competitive bidding areas was based on supplier bids. The program started in nine metropolitan areas in January 2011 and had expanded to 130 competitive bidding areas in 2018. As of January 1, 2019, the program was suspended to establish a new bidding methodology; the final rule for the new methodology was published November 14, 2018. The program is expected to resume in 2021, with payments for included DMEPOS based on bids submitted by suppliers by September 2019. Before it was suspended, certain equipment was exempted from the program when provided by a physician or other practitioner to his/her own patients as part of his/her professional services.

Under Part B, Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. There is a list of over 7,000 tasks and services that physicians bill Medicare for. The fee schedule assigns relative values to each service code that reflect physician work (based on time, skill, and intensity involved), practice expenses (e.g., overhead and non-physician labor), and malpractice expenses. The relative values are adjusted for geographic variations in the cost of the inputs required to furnish the service. These geographically adjusted relative values are converted into a dollar payment amount by a national conversion factor.

The Centers for Medicare & Medicaid Services (CMS) is responsible for maintaining and updating the fee schedule at least every five years, including the modification and refinement of the methodology for establishing relative value units. The Patient Protection and Affordable Care Act[7] gave the HHS Secretary additional authority to periodically identify physician services as being potentially misvalued, and to make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. These adjustments are to be made in a budget-neutral manner.

Medicare benefits are financed through two trust funds maintained by the Department of the Treasury—the Hospital Insurance (HI) trust fund for Medicare Part A and the Supplementary Medical Insurance (SMI) trust fund for Medicare Parts B and D. In addition, some amounts are transferred from the trust funds to the CMS Program Management account each year to support costs of administering the Medicare program. This cross-cutting account supports CMS program operations (e.g., claims processing, information technology investments, provider and beneficiary outreach and education, and program implementation), in addition to federal administration, other activities related to the administration of Medicare, and other programs.

REASONS FOR CHANGE

To modernize and improve Part B coverage by adding long-needed benefits for vision services to determine the refractive state of the eye and coverage for conventional eyeglasses or contact lenses, which are currently not a covered benefit under Medicare Part B.

[7] P.L. 111–148, ACA, as amended.

EXPLANATION OF PROVISIONS

Section 1. Short title

The short title for the bill is the "Medicare Vision Act of 2019."

Section 2. Providing coverage for vision care under the Medicare program

This section adds to Medicare Part B coverage for routine eye examinations to determine the refractive state of the eyes (including procedures performed during the exam) and contact lens fitting services. Beginning on January 1, 2022, Medicare will begin reimbursing ophthalmologists and optometrists for one routine eye examination and one session of contact lens fitting services every two years. Payment to providers will be made under the Physician Fee Schedule with beneficiaries responsible for 20 percent of the cost-sharing.

The section waives budget neutrality requirements for payment for dental services under the physician fee schedule for 2022 and 2023.

The section clarifies that individuals who have had cataract surgery with insertion of intraocular lens still have access to coverage of glasses or contact lenses post-surgery if they have already received glasses or contact lenses through the new vision benefit.

The new benefit will also cover either one pair of eyeglasses during a two-year period or a two-year supply of contact lenses provided in 180-day increments if furnished with a written physician order. Medicare will pay up to $100 in 2022 (increasing each year by the percentage change in the Consumer Price Index for All Urban Consumers) toward the cost of either the eyeglass frames or contact lenses, the appropriate types of which will be determined by the Secretary. Payment will be made for one pair of eyeglasses or contacts lenses for individuals who have cataract surgery with insertion of intraocular lens and subsequently have a routine eye examination during the two-year period.

Payment for eyeglasses and contact lenses will be made through Medicare's competitive bidding program for orthotics and prosthetics. Eyeglasses or contact lenses furnished by a physician or other practitioner as part of the physician's or practitioner's professional service will be excluded from competitive bidding.

Section 3. Implementation funding

This section provides implementation funding as necessary from the Federal Supplementary Medical Insurance Trust Fund to the Secretary of the Department of Health and Human Services for 2020–2024.

EFFECTIVE DATE

Section 2: Effective beginning on or after January 1, 2022.

III. VOTES OF THE COMMITTEE

Pursuant to clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup con-

sideration of H.R. 4665, the Medicare Vision Act of 2019 on October 22, 2019.

The Chairman's amendment in the nature of a substitute was agreed to by voice vote (with a quorum being present).

H.R. 4665 as amended was ordered favorably reported to the House of Representatives by voice vote (with a quorum being present).

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

Clause 3(d)(1) of the Rules of the House of Representatives requires an estimate and a comparison of costs that would be incurred in carrying out H.R. 4665. The Committee traditionally adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office (CBO) pursuant to section 402 of the Congressional Budget Act of 1974. The Committee reports that because this cost estimate was not timely submitted to the Committee before the filing of this report, the Committee is not in a position to make a cost estimate for H.R. 4665, as amended.

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

Pursuant to clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee further states that the bill involves no new tax expenditure.

C. Cost Estimate Prepared by the Congressional Budget Office

With respect to the requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the Committee has requested but not received a cost estimate for the bill from the Director of the Congressional Budget Office.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee made findings and recommendations that are reflected in this report.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

E. Duplication of Federal Programs

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report to Congress pursuant to section 21 of Public Law 111–139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant section 6104 of title 31, United States Code.

F. Hearings

In compliance with Sec. 103(i) of H. Res. 6 (116th Congress) (1) the following hearing was used to develop or consider H.R. 4665:

On October 17, 2019, the Committee on Ways and Means held a full committee hearing entitled, "Investing in the U.S. Health System By Lowering Drug Prices, Reducing Out-of-Pocket Costs and Improving Medicare Benefits," to discuss how H.R. 4665, the Medicare Vision Act of 2019, will lower prescription drug prices in Medicare and the commercial market, improve affordability of medicine, and reduce costs for patients and taxpayers. In addition, the Committee received testimony on how savings from H.R. 4665 can be reinvested to improve care and lower costs for seniors and people with disabilities enrolled in Medicare, including the addition of vision services.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I) on the basis of a fee schedule under subsection (h)(1) (for tests furnished before January 1, 2017) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests,

or (II) undersection 1834A (for tests furnished on or after January1, 2017), the amount paid shall be equal to 80 percent(or 100 percent, in the case of such tests for whichpayment is made on an assignment-related basis) ofthe lesser of the amount determined under such sectionor the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017,on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate,,(E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881,(F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L),

(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system,

(H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and(J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent (or 100 percent for services furnished on or after January 1, 2011) of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the

purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)) other than personalized prevention plan services (as defined in section 1861(hhh)(1)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services, (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1861(zz))) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o) (or, if applicable, under section 1847, 1847A, or 1847B), (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be 80 percent (or 100 percent if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual) of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5), (W) with respect to additional preventive services (as defined in section

1861(ddd)(1)), the amount paid shall be (i) in the case of such services which are clinical diagnostic laboratory tests, the amount determined under subparagraph (D) (if such subparagraph were applied, by substituting "100 percent" for "80 percent"), and (ii) in the case of all other such services, 100 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph, (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848, (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t), (Z) with respect to Federally qualified health center services for which payment is made under section 1834(o), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount determined under such section, (AA) with respect to an applicable disposable device (as defined in paragraph (2) of section 1834(s)) furnished to an individual pursuant to paragraph (1) of such section, the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under paragraph (3) of such section, (BB) with respect to home infusion therapy, the amount paid shall be an amount equal to 80 percent of the lesser of the actual charge for the services or the amount determined under section 1834(u), [and] (CC) with respect to opioid use disorder treatment services furnished during an episode of care, the amount paid shall be equal to the amount payable under section 1834(w) less any copayment required as specified by the Secretary*, and (DD) with respect to vision services (as defined in section 1861(kkk)), the amount paid shall be equal to 80 percent of the lesser of the actual charge or the amount determined under the payment basis determined under section 1848*;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this para-

graph and except as may be provided in section 1886 or section 1888(e)(9))—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,—less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

(iv) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i)(I)on the basis of a fee schedule determined under subsection(h)(1) (for tests furnished before January 1, 2017) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii) for tests furnished before January 1, 2017, on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imag-

ing, and ultrasound and other imaging services, but excluding screening mammography and, for services furnished on or after January 1, 2005, diagnostic mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n) or, for services or procedures performed on or after January 1, 1999, subsection (t);

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v);

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services; and

(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(3) in the case of services described in section 1832(a)(2)(D)—

(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1853(a)(4), the amount (if any) by which—

(i) the amount of payment that would have otherwise been provided (I) under subparagraph (A) (calculated as if "100 percent" were substituted for "80 percent" in such subparagraph) for such services if the individual had not been so enrolled, or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under

section 1834(o), under such section (calculated as if "100 percent" were substituted for "80 percent" in such section) for such services if the individual had not been so enrolled; exceeds

(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the federally qualified health center may charge as described in section 1857(e)(3)(B);

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);

(6) in the case of outpatient critical access hospital services, the amounts described in section 1834(g);

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h);

(8) in the case of—

(A) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1834(k); and

(9) in the case of services described in section 1832(a)(2)(E) that are not described in paragraph (8), the amounts described in section 1834(k).

Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(0).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred ex-

penses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual., (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) for tests furnished before January 1, 2017,on the basis of a negotiated rate determined under subsection (h)(6), (4) such deductible shall not apply to Federally qualified health center services, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1861(bbb)), (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1)), (9) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww)), and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year. Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code

that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

(c)(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

(A) for expenses incurred in years prior to 2010, only 62½ percent of such expenses;

(B) for expenses incurred in 2010 or 2011, only 68¾ percent of such expenses;

(C) for expenses incurred in 2012, only 75 percent of such expenses;

(D) for expenses incurred in 2013, only 81¼ percent of such expenses; and

(E) for expenses incurred in 2014 or any subsequent calendar year, 100 percent of such expenses.

(2) For purposes of subparagraphs (A) through (D) of paragraph (1), the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (other than such clinics in hospitals with less than 50 beds), the Secretary shall establish such limit, for services provided—

(1) in 1988, after March 31, at $46 per visit, and

(2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.

(g)(1)(A) Subject to paragraphs (4) and (5), in the case of physical therapy services of the type described in section 1861(p) and speech-language pathology services of the type described in such section through the application of section 1861(ll)(2), but (except as provided in paragraph (6)) not described in subsection (a)(8)(B), and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2)

for the year shall be considered as incurred expenses for purposes of subsections (a) and (b). The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.

(B) With respect to services furnished during 2018 or a subsequent year, in the case of physical therapy services of the type described in section 1861(p), speech-language pathology services of the type described in such section through the application of section 1861(ll)(2), and physical therapy services and speech-language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.

(2) The amount specified in this paragraph—

(A) for 1999, 2000, and 2001, is $1,500, and

(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3)(A) Subject to paragraphs (4) and (5), in the case of occupational therapy services (of the type that are described in section 1861(p) (but (except as provided in paragraph (6)) not described in subsection (a)(8)(B)) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b). The preceding sentence shall not apply to expenses incurred with respect to services furnished after December 31, 2017.

(B) With respect to services furnished during 2018 or a subsequent year, in the case of occupational therapy services (of the type that are described in section 1861(p) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services), with respect to expenses incurred in any calendar year, any amount that is more than the amount specified in paragraph (2) for the year shall not be considered as incurred expenses for purposes of subsections (a) and (b) unless the applicable requirements of paragraph (7) are met.

(4) This subsection shall not apply to expenses incurred with respect to services furnished during 2000, 2001, 2002, 2004, and 2005.

(5)(A) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, 2017, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary and if the require-

ment of subparagraph (B) is met. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request made in accordance with such requirement, the Secretary shall be deemed to have found the services to be medically necessary.

(B) In the case of outpatient therapy services for which an exception is requested under the first sentence of subparagraph (A), the claim for such services shall contain an appropriate modifier (such as the KX modifier used as of the date of the enactment of this subparagraph) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(C)(i) In applying this paragraph with respect to a request for an exception with respect to expenses that would be incurred for outpatient therapy services (including services described in subsection (a)(8)(B)) that would exceed the threshold described in clause (ii) for a year, the request for such an exception, for services furnished on or after October 1, 2012, shall be subject to a manual medical review process that, subject to subparagraph (E), is similar to the manual medical review process used for certain exceptions under this paragraph in 2006.

(ii) The threshold under this clause for a year is $3,700. Such threshold shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(E)(i) In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a "therapy provider") using such factors as the Secretary determines to be appropriate.

(ii) Such factors may include the following:

(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.

(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

(III) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.

(IV) The services are furnished to treat a type of medical condition.

(V) The therapy provider is part of group that includes another therapy provider identified using the factors determined under this subparagraph.

(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to re-

main available until expended. Such funds may not be used by a contractor under section 1893(h) for medical reviews under this subparagraph.

(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented, except as such process is applied under paragraph (7)(B).

(6)(A) In applying paragraphs (1) and (3) to services furnished during the period beginning not later than October 1, 2012, and ending on December 31, 2017, the exclusion of services described in subsection (a)(8)(B) from the uniform dollar limitation specified in paragraph (2) shall not apply to such services furnished during 2012 through 2017.

(B)(i) With respect to outpatient therapy services furnished beginning on or after January 1, 2013, and before January 1, 2014, for which payment is made under section 1834(g), the Secretary shall count toward the uniform dollar limitations described in paragraphs (1) and (3) and the threshold described in paragraph (5)(C) the amount that would be payable under this part if such services were paid under section 1834(k)(1)(B) instead of being paid under section 1834(g).

(ii) Nothing in clause (i) shall be construed as changing the method of payment for outpatient therapy services under section 1834(g).

(7) For purposes of paragraphs (1)(B) and (3)(B), with respect to services described in such paragraphs, the requirements described in this paragraph are as follows:

(A) INCLUSION OF APPROPRIATE MODIFIER.—The claim for such services contains an appropriate modifier (such as the KX modifier described in paragraph (5)(B)) indicating that such services are medically necessary as justified by appropriate documentation in the medical record involved.

(B) TARGETED MEDICAL REVIEW FOR CERTAIN SERVICES ABOVE THRESHOLD.—

(i) IN GENERAL.—In the case where expenses that would be incurred for such services would exceed the threshold described in clause (ii) for the year, such services shall be subject to the process for medical review implemented under paragraph (5)(E).

(ii) THRESHOLD.—The threshold under this clause for—

(I) a year before 2028, is $3,000;

(II) 2028, is the amount specified in subclause (I) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for 2028; and

(III) a subsequent year, is the amount specified in this clause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subclause (II) or (III) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(iii) APPLICATION.—The threshold under clause (ii) shall be applied separately—

(I) for physical therapy services and speech-language pathology services; and

(II) for occupational therapy services.

(iv) FUNDING.—For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account, of $5,000,000 for each fiscal year beginning with fiscal year 2018, to remain available until expended. Such funds may not be used by a contractor under section 1893(h) for medical reviews under this subparagraph.

(8) With respect to services furnished on or after January 1, 2013, where payment may not be made as a result of application of paragraphs (1) and (3), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

(h)(1)(A) Subject to section 1834(d)(1), the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

(B) In the case of clinical diagnostic laboratory tests performed by a physician or by a laboratory (other than tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital), the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(C) In the case of clinical diagnostic laboratory tests performed by a qualified hospital laboratory (as defined in subparagraph (D)) for outpatients of such hospital, the fee schedules established under subparagraph (A) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished on or after July 1, 1984.

(D) In this subsection, the term "qualified hospital laboratory" means a hospital laboratory, in a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.

(2)(A)(i) Except as provided in clause (v), subparagraph (B), and paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to clause (iv), a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average) minus, for each of the years 2009 and 2010, 0.5 percentage points, and, for tests

furnished before the dateof enactment of section 1834A, subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988,

(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988,

(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent, and

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995, 1998 through 2002, and 2004 through 2008 shall be 0 percent.

(iii) In establishing fee schedules under clause (i) with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on lowest charge levels under the sixth sentence of section 1842(b)(3) performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988, and such reduced fee schedules shall serve as the base for 1989 and subsequent years.

(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—

(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall not result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.

(v) The Secretary shall reduce by 2 percent the fee schedules otherwise determined under clause (i) for 2013, and such reduced fee schedules shall serve as the base for 2014 and subsequent years.

(B) The Secretary may make further adjustments or exceptions to the fee schedules to assure adequate reimbursement of (i) emergency laboratory tests needed for the provision of bona fide emergency services, and (ii) certain low volume high-cost tests where highly sophisticated equipment or extremely skilled personnel are necessary to assure quality.

(3) In addition to the amounts provided under the fee schedules (for tests furnished before January 1, 2017)or under section 1834A (for tests furnished on or afterJanuary 1, 2017), subject to subsection (b)(5) of such section, the Secretary shall provide for and establish (A) a nominal fee to cover the appropriate costs in collecting the sample on which a clinical diagnostic laboratory test was performed and for which payment is made under this part, except that

not more than one such fee may be provided under this paragraph with respect to samples collected in the same encounter, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital). In establishing a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect a sample, the Secretary shall provide a method for computing the fee based on the number of miles traveled and the personnel costs associated with the collection of each individual sample, but the Secretary shall only be required to apply such method in the case of tests furnished during the period beginning on April 1, 1989, and ending on December 31, 1990, by a laboratory that establishes to the satisfaction of the Secretary (based on data for the 12-month period ending June 30, 1988) that (i) the laboratory is dependent upon payments under this title for at least 80 percent of its collected revenues for clinical diagnostic laboratory tests, (ii) at least 85 percent of its gross revenues for such tests are attributable to tests performed with respect to individuals who are homebound or who are residents in a nursing facility, and (iii) the laboratory provided such tests for residents in nursing facilities representing at least 20 percent of the number of such facilities in the State in which the laboratory is located.

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) on or after July 1, 1986, and before April 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(ii) after March 31, 1988, and before January 1, 1990, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iii) after December 31, 1989, and before January 1, 1991, is equal to 93 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1),

(iv) after December 31, 1990, and before January 1, 1994, is equal to 88 percent of such median,

(v) after December 31, 1993, and before January 1, 1995, is equal to 84 percent of such median,

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median,

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median, and

(viii) after December 31, 1997, is equal to 74 percent of such median (or 100 percent of such median in the case of a clinical

diagnostic laboratory test performed on or after January 1, 2001, that the Secretary determines is a new test for which no limitation amount has previously been established under this subparagraph).

(5)(A) In the case of a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part on an assignment-related basis or under a provider agreement under section 1866, payment may be made only to the person or entity which performed or supervised the performance of such test; except that—

(i) if a physician performed or supervised the performance of such test, payment may be made to another physician with whom he shares his practice,

(ii) in the case of a test performed at the request of a laboratory by another laboratory, payment may be made to the referring laboratory but only if—

(I) the referring laboratory is located in, or is part of, a rural hospital,

(II) the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity, or

(III) not more than 30 percent of the clinical diagnostic laboratory tests for which such referring laboratory (but not including a laboratory described in subclause (II)), receives requests for testing during the year in which the test is performed are performed by another laboratory, and

(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1861(w)(1)) made by a hospital, critical access hospital, or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility.

(B) In the case of such a bill or request for payment for a clinical diagnostic laboratory test for which payment may otherwise be made under this part, and which is not described in subparagraph (A), payment may be made to the beneficiary only on the basis of the itemized bill of the person or entity which performed or supervised the performance of the test.

(C) Payment for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic may only be made on an assignment-related basis or to a provider of services with an agreement in effect under section 1866.

(D) A person may not bill for a clinical diagnostic laboratory test, including a test performed in a physician's office but excluding a test performed by a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence, the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with paragraph (2) of section 1842(j) in the same manner such paragraphs apply with respect to a physician. Paragraph (4) of such section shall apply in

this subparagraph in the same manner as such paragraph applies to such section.

(6) For tests furnished before January 1, 2017, inthe case of any diagnostic laboratory test payment for which is not made on the basis of a fee schedule under paragraph (1), the Secretary may establish a payment rate which is acceptable to the person or entity performing the test and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such rate.

(7) Notwithstanding paragraphs (1) and (4)and section 1834A, the Secretary shall establish a national minimum payment amount under this part for a diagnostic or screening pap smear laboratory test (including all cervical cancer screening technologies that have been approved by the Food and Drug Administration as a primary screening method for detection of cervical cancer) equal to $14.60 for tests furnished in 2000. For such tests furnished in subsequent years, such national minimum payment amount shall be adjusted annually as provided in paragraph (2).

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as "new tests").

(B) Determinations under subparagraph (A) shall be made only after the Secretary—

(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

(v) taking into account the comments received during the public comment period, develops and makes available to the

public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

(E) For purposes of this paragraph:

(i) The term "HCPCS" refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be "substantially revised" if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).

(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or after April 1, 2008, the payment rate for such test shall be the payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).

(i)(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in an ambulatory surgical center (meeting the standards specified under section 1832(a)(2)(F)(i)), critical access hospital, or hospital outpatient department, and

(B) specify those surgical procedures which are appropriately (when considered in terms of the proper utilization of hospital inpatient facilities) performed on an inpatient basis in a hospital but which also can be performed safely on an ambulatory basis in a physician's office.

The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years, in consultation with appropriate trade and professional organizations.

(2)(A) For services furnished prior to the implementation of the system described in subparagraph (D), subject to subparagraph (E), the amount of payment to be made for facility services furnished in connection with a surgical procedure specified pursuant to paragraph (1)(A) and furnished to an individual in an ambulatory surgical center described in such paragraph shall be equal to 80 percent of a standard overhead amount established by the Secretary

(with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account the costs incurred by such centers, or classes of centers, generally in providing services furnished in connection with the performance of such procedure, as determined in accordance with a survey (based upon a representative sample of procedures and facilities) of the actual audited costs incurred by such centers in providing such services,

(ii) takes such costs into account in such a manner as will assure that the performance of the procedure in such a center will result in substantially less amounts paid under this title than would have been paid if the procedure had been performed on an inpatient basis in a hospital, and

(iii) in the case of insertion of an intraocular lens during or subsequent to cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(B) The amount of payment to be made under this part for facility services furnished, in connection with a surgical procedure specified pursuant to paragraph (1)(B), in a physician's office shall be equal to 80 percent of a standard overhead amount established by the Secretary (with respect to each such procedure) on the basis of the Secretary's estimate of a fair fee which—

(i) takes into account additional costs, not usually included in the professional fee, incurred by physicians in securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and

(ii) takes such items into account in such a manner which will assure that the performance of such procedure in the physician's office will result in substantially less amounts paid under this title than would have been paid if the services had been furnished on an inpatient basis in a hospital.

Each amount so established shall be reviewed and updated not later than July 1, 1987, and annually thereafter to take account of varying conditions in different areas.

(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the

Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.

(D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

(iv) The Secretary may implement such system in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7).

(v) In implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in such update being less than 0.0 for a year, and may result in payment rates under the system described in clause (i) for a year being less than such payment rates for the preceding year.

(vi) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.

(E) With respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system under subparagraph (D), if—

(i) the standard overhead amount under subparagraph (A) for a facility service for such procedure, without the application of any geographic adjustment, 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 1833(t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section,

the Secretary shall substitute under subparagraph (A) the amount described in clause (ii) for the standard overhead amount for such service referred to in clause (i).

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or critical access hospital services furnished before January 1, 1999, in connection

with surgical procedures specified under paragraph (1)(A) shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) Subject to paragraph (4), in this paragraph:

(I) The term "cost proportion" means 75 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "ASC proportion" means 25 percent for cost reporting periods beginning in fiscal year 1988, 50 percent for portions of cost reporting periods beginning on or after October 1, 1988, and ending on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.

(4)(A) In the case of a hospital that—

(i) makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary),

(ii) receives more than 30 percent of its total revenues from outpatient services, and

(iii) on October 1, 1987—

(I) was an eye specialty hospital or an eye and ear specialty hospital, or

(II) was operated as an eye or eye and ear unit (as defined in subparagraph (B)) of a general acute care hospital which, on the date of the application described in clause (i), operates less than 20 percent of the beds that the hospital operated on October 1, 1987, and has sold or otherwise disposed of a substantial portion of the hospital's other acute care operations,

the cost proportion and ASC proportion in effect under subclauses (I) and (II) of paragraph (3)(B)(ii) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

(B) For purposes of this subparagraph (A)(iii)(II), the term "eye or eye and ear unit" means a physically separate or distinct unit containing separate surgical suites devoted solely to eye or eye and ear services.

(5)(A) The Secretary is authorized to provide by regulations that in the case of a surgical procedure, specified by the Secretary pur-

suant to paragraph (1)(A), performed in an ambulatory surgical center described in such paragraph, there shall be paid (in lieu of any amounts otherwise payable under this part) with respect to the facility services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to subparagraph (B), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(B) In implementing this paragraph, the Secretary shall establish with respect to each surgical procedure specified pursuant to paragraph (1)(A) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall be reviewed periodically and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(6) Any person, including a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(7)(A) For purposes of paragraph (2)(D)(iv), the Secretary may provide, in the case of an ambulatory surgical center that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to a year, any annual increase provided under the system established under paragraph (2)(D) for such year shall be reduced by 2.0 percentage points. A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing any annual increase factor for a subsequent year.

(B) Except as the Secretary may otherwise provide, the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of section 1833(t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.

(8) The Secretary shall conduct a similar type of review as required under paragraph (22) of section 1833(t)), including the second sentence of subparagraph (C) of such paragraph, to payment for services under this subsection, and make such revisions under this paragraph, in an appropriate manner (as determined by the Secretary).

(j) Whenever a final determination is made that the amount of payment made under this part either to a provider of services or

to another person pursuant to an assignment under section 1842(b)(3)(B)(ii) was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

(k) With respect to services described in section 1861(s)(10)(B), the Secretary may provide, instead of the amount of payment otherwise provided under this part, for payment of such an amount or amounts as reasonably reflects the general cost of efficiently providing such services.

(l)(1)(A) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.

(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985 and such other data as the Secretary determines necessary.

(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid plus applicable coinsurance but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

(i) the conversion factor shall be—

(I) for services furnished in 1991, $15.50,

(II) for services furnished in 1992, $15.75,

(III) for services furnished in 1993, $16.00,

(IV) for services furnished in 1994, $16.25,

(V) for services furnished in 1995, $16.50,

(VI) for services furnished in 1996, $16.75, and

(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1848(d) for physician anesthesia services for that year;

(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services furnished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, and before January 1, 1994, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

(ii) The conversion factor used under clause (i) shall be—

(I) for services furnished in 1991, $10.50,

(II) for services furnished in 1992, $10.75, and

(III) for services furnished in 1993, $11.00.

(iii) In the case of services of a certified registered nurse anesthetist who is medically directed or medically supervised by a physician which are furnished on or after January 1, 1994, the fee schedule amount shall be one-half of the amount described in section 1848(a)(5)(B) with respect to the physician.

(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

(i) in the case of a 1990 conversion factor that is greater than $16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by the product of the last digit of the calendar year and one-fifth of

the amount by which the 1990 conversion factor exceeds $16.50; and

(ii) in the case of a 1990 conversion factor that is greater than $15.49 but less than $16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

(I) the 1990 conversion factor, or

(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality.

(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, critical access hospital, physician, group practice, or ambulatory surgical center with which the certified registered nurse anesthetist furnishing such services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, critical access hospital, physician, group practice, or ambulatory surgical center.

(B) No hospital or critical access hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital or critical access hospital for purposes of this title.

(6) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians' service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1842(j)(1)(D).

(m)(1) In the case of physicians' services furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

(A) the identification of a county or area;

(B) the assignment of a specialty of any physician under this paragraph;

(C) the assignment of a physician to a county under this subsection; or

(D) the assignment of a postal ZIP Code to a county or other area under this subsection.

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

(ii) In this subparagraph:

(I) The term "cost proportion" means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.

(II) The term "charge proportion" means 100 percent minus the cost proportion.

(o)(1) In the case of shoes described in section 1861(s)(12)—

(A) no payment may be made under this part, with respect to any individual for any year, for the furnishing of—

(i) more than one pair of custom molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts for such shoes, or

(ii) more than one pair of extra-depth shoes (not including inserts provided with such shoes) and 3 pairs of inserts for such shoes, and

(B) with respect to expenses incurred in any calendar year, no more than the amount of payment applicable under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes (or inserts) under this part shall be considered to include payment for any expenses for the fitting of such shoes (or inserts).

(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.

(3) In this title, the term "shoes" includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.

[(p) Striken.]

(q)(1) Each request for payment, or bill submitted, for an item or service furnished by an entity for which payment may be made under this part and for which the entity knows or has reason to believe there has been a referral by a referring physician (within the meaning of section 1877) shall include the name and unique physician identification number for the referring physician.

(2)(A) In the case of a request for payment for an item or service furnished by an entity under this part on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included, payment may be denied under this part.

(B) In the case of a request for payment for an item or service furnished by an entity under this part not submitted on an assignment-related basis and for which information is required to be provided under paragraph (1) but not included—

(i) if the entity knowingly and willfully fails to provide such information promptly upon request of the Secretary or a carrier, the entity may be subject to a civil money penalty in an amount not to exceed $2,000, and

(ii) if the entity knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection to provide the information required under paragraph (1), the entity may be subject to exclusion from participation in the programs under this Act for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under clause (i) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(r)(1) With respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, critical access hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

(2) No hospital or critical access hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(ii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

(s) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has ex-

hausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

(iii) includes implantable items described in paragraph (3), (6), or (8) of section 1861(s);

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include screening mammography (as defined in section 1861(jj)), diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1)); and

(v) does not include applicable items and services (as defined in subparagraph (A) of paragraph (21)) that are furnished on or after January 1, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph).

(2) SYSTEM REQUIREMENTS.—Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources and so that an implantable item is classified to the group that includes the service to which the item relates;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median (or, at the election of the Secretary, mean) hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) subject to paragraph (19), the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish, in a budget neutral manner, outlier adjustments under paragraph (5) and transitional pass-through payments under paragraph (6) and other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals;

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services;

(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedures that utilize contrast agents from those that do not; and

(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices and for stranded and non-stranded devices furnished on or after July 1, 2007.

For purposes of subparagraph (B), items and services within a group shall not be treated as "comparable with respect to the use of resources" if the highest median cost (or mean cost, if elected by the Secretary under subparagraph (C)) for an item or service within the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the group; except that the Secretary may make exceptions in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) CALCULATION OF BASE AMOUNTS.—

(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the sum of—

(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and

(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under section 1833(b) did not apply.

(B) UNADJUSTED COPAYMENT AMOUNT.—

(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the "unadjusted copayment amount" applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not fur-

nished during 1996, based upon its classification within a group of such services.

(C) CALCULATION OF CONVERSION FACTORS.—

(i) FOR 1999.—

(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) PRODUCT DESCRIBED.—The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iv) for the year involved.

(iii) ADJUSTMENT FOR SERVICE MIX CHANGES.—Insofar as the Secretary determines that the adjustments for service mix under paragraph (2) for a previous year (or estimates that such adjustments for a future year) did (or are likely to) result in a change in aggregate payments under this subsection during the year that are a result of changes in the coding or classification of covered OPD services that do not reflect real changes in service mix, the Secretary may adjust the conversion factor computed under this subparagraph for subsequent years so as to eliminate the effect of such coding or classification changes.

(iv) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, subject to paragraph (17) and subparagraph (F) of this paragraph, the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same

manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(E) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

(F) PRODUCTIVITY AND OTHER ADJUSTMENT.—After determining the OPD fee schedule increase factor under subparagraph (C)(iv), the Secretary shall reduce such increase factor—

(i) for 2012 and subsequent years, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II); and

(ii) for each of 2010 through 2019, by the adjustment described in subparagraph (G).

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(G) OTHER ADJUSTMENT.—For purposes of subparagraph (F)(ii), the adjustment described in this subparagraph is—

(i) for each of 2010 and 2011, 0.25 percentage point;

(ii) for each of 2012 and 2013, 0.1 percentage point;

(iii) for 2014, 0.3 percentage point;

(iv) for each of 2015 and 2016, 0.2 percentage point; and

(v) for each of 2017, 2018, and 2019, 0.75 percentage point.

(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined, subject to paragraph (7), as follows:

(A) FEE SCHEDULE ADJUSTMENTS.—The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors deter-

mined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved, plus the amount of any reduction in the copayment amount attributable to paragraph (8)(C).

(5) OUTLIER ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraph (D), the Secretary shall provide for an additional payment for each covered OPD service (or group of services) for which a hospital's charges, adjusted to cost, exceed—

(i) a fixed multiple of the sum of—

(I) the applicable medicare OPD fee schedule amount determined under paragraph (3)(D), as adjusted under paragraph (4)(A) (other than for adjustments under this paragraph or paragraph (6)); and

(II) any transitional pass-through payment under paragraph (6); and

(ii) at the option of the Secretary, such fixed dollar amount as the Secretary may establish.

(B) AMOUNT OF ADJUSTMENT.—The amount of the additional payment under subparagraph (A) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the applicable cutoff point under such subparagraph.

(C) LIMIT ON AGGREGATE OUTLIER ADJUSTMENTS.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means a percentage specified by the Secretary up to (but not to exceed)—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, 3.0 percent.

(D) TRANSITIONAL AUTHORITY.—In applying subparagraph (A) for covered OPD services furnished before January 1, 2002, the Secretary may—

(i) apply such subparagraph to a bill for such services related to an outpatient encounter (rather than for a specific service or group of services) using OPD fee schedule amounts and transitional pass-through payments covered under the bill; and

(ii) use an appropriate cost-to-charge ratio for the hospital involved (as determined by the Secretary), rather than for specific departments within the hospital.

(E) EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.

(6) TRANSITIONAL PASS-THROUGH FOR ADDITIONAL COSTS OF INNOVATIVE MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—

(A) IN GENERAL.—The Secretary shall provide for an additional payment under this paragraph for any of the following that are provided as part of a covered OPD service (or group of services):

(i) CURRENT ORPHAN DRUGS.—A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this subsection is implemented.

(ii) CURRENT CANCER THERAPY DRUGS AND BIOLOGICALS AND BRACHYTHERAPY.—A drug or biological that is used in cancer therapy, including (but not limited to) a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy or temperature monitored cryoablation, if payment for such drug, biological, or device as an outpatient hospital service under this part was being made on such first date.

(iii) CURRENT RADIOPHARMACEUTICAL DRUGS AND BIOLOGICAL PRODUCTS.—A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on such first date.

(iv) NEW MEDICAL DEVICES, DRUGS, AND BIOLOGICALS.—A medical device, drug, or biological not described in clause (i), (ii), or (iii) if—

(I) payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(II) the cost of the drug or biological or the average cost of the category of devices is not insignificant in relation to the OPD fee schedule amount

(as calculated under paragraph (3)(D)) payable for the service (or group of services) involved.

(B) USE OF CATEGORIES IN DETERMINING ELIGIBILITY OF A DEVICE FOR PASS-THROUGH PAYMENTS.—The following provisions apply for purposes of determining whether a medical device qualifies for additional payments under clause (ii) or (iv) of subparagraph (A):

(i) ESTABLISHMENT OF INITIAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall initially establish under this clause categories of medical devices based on type of device by April 1, 2001. Such categories shall be established in a manner such that each medical device that meets the requirements of clause (ii) or (iv) of subparagraph (A) as of January 1, 2001, is included in such a category and no such device is included in more than one category. For purposes of the preceding sentence, whether a medical device meets such requirements as of such date shall be determined on the basis of the program memoranda issued before such date.

(II) AUTHORIZATION OF IMPLEMENTATION OTHER THAN THROUGH REGULATIONS.—The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall include a test of whether the average cost of devices that would be included in a category and are in use at the time the category is established is not insignificant, as described in subparagraph (A)(iv)(II).

(III) DEADLINE.—Criteria shall first be established under this clause by July 1, 2001. The Secretary may establish in compelling circumstances categories under this clause before the date such criteria are established.

(IV) ADDING CATEGORIES.—The Secretary shall promptly establish a new category of medical devices under this clause for any medical device that meets the requirements of subparagraph (A)(iv) and for which none of the categories in effect (or that were previously in effect) is appropriate.

(iii) PERIOD FOR WHICH CATEGORY IS IN EFFECT.—A category of medical devices established under clause

(i) or (ii) shall be in effect for a period of at least 2 years, but not more than 3 years, that begins—

(I) in the case of a category established under clause (i), on the first date on which payment was made under this paragraph for any device described by such category (including payments made during the period before April 1, 2001); and

(II) in the case of any other category, on the first date on which payment is made under this paragraph for any medical device that is described by such category.

(iv) REQUIREMENTS TREATED AS MET.—A medical device shall be treated as meeting the requirements of subparagraph (A)(iv), regardless of whether the device meets the requirement of subclause (I) of such subparagraph, if—

(I) the device is described by a category established and in effect under clause (i); or

(II) the device is described by a category established and in effect under clause (ii) and an application under section 515 of the Federal Food, Drug, and Cosmetic Act has been approved with respect to the device, or the device has been cleared for market under section 510(k) of such Act, or the device is exempt from the requirements of section 510(k) of such Act pursuant to subsection (l) or (m) of section 510 of such Act or section 520(g) of such Act.

Nothing in this clause shall be construed as requiring an application or prior approval (other than that described in subclause (II)) in order for a covered device described by a category to qualify for payment under this paragraph.

(C) LIMITED PERIOD OF PAYMENT.—

(i) DRUGS AND BIOLOGICALS.—Subject to subparagraph (G), the payment under this paragraph with respect to a drug or biological shall only apply during a period of at least 2 years, but not more than 3 years, that begins—

(I) on the first date this subsection is implemented in the case of a drug or biological described in clause (i), (ii), or (iii) of subparagraph (A) and in the case of a drug or biological described in subparagraph (A)(iv) and for which payment under this part is made as an outpatient hospital service before such first date; or

(II) in the case of a drug or biological described in subparagraph (A)(iv) not described in subclause (I), on the first date on which payment is made under this part for the drug or biological as an outpatient hospital service.

(ii) MEDICAL DEVICES.—Payment shall be made under this paragraph with respect to a medical device only if such device—

(I) is described by a category of medical devices established and in effect under subparagraph (B); and

(II) is provided as part of a service (or group of services) paid for under this subsection and provided during the period for which such category is in effect under such subparagraph.

(D) AMOUNT OF ADDITIONAL PAYMENT.—Subject to subparagraph (E)(iii), the amount of the payment under this paragraph with respect to a device, drug, or biological provided as part of a covered OPD service is—

(i) subject to subparagraph (H), in the case of a drug or biological, the amount by which the amount determined under section 1842(o) (or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph) for the drug or biological exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the drug or biological; or

(ii) in the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable medicare OPD fee schedule that the Secretary determines is associated with the device.

(E) LIMIT ON AGGREGATE ANNUAL ADJUSTMENT.—

(i) IN GENERAL.—The total of the additional payments made under this paragraph for covered OPD services furnished in a year (as estimated by the Secretary before the beginning of the year) may not exceed the applicable percentage (specified in clause (ii)) of the total program payments estimated to be made under this subsection for all covered OPD services furnished in that year. If this paragraph is first applied to less than a full year, the previous sentence shall apply only to the portion of such year. This clause shall not apply for 2018.

(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term "applicable percentage" means—

(I) for a year (or portion of a year) before 2004, 2.5 percent; and

(II) for 2004 and thereafter, a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

(iii) UNIFORM PROSPECTIVE REDUCTION IF AGGREGATE LIMIT PROJECTED TO BE EXCEEDED.—If the Secretary estimates before the beginning of a year that the amount of the additional payments under this paragraph for the year (or portion thereof) as determined under clause (i) without regard to this clause will exceed the limit established under such clause, the Sec-

retary shall reduce pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed such limit.

(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 unless—

(I) such application was being made to such drug or biological prior to such date of enactment; and

(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

(G) PASS-THROUGH EXTENSION FOR CERTAIN DRUGS AND BIOLOGICALS.—In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2018, such pass-through status shall be extended for a 2-year period beginning on October 1, 2018.

(H) TEMPORARY PAYMENT RULE FOR CERTAIN DRUGS AND BIOLOGICALS.—In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of services) furnished beginning January 1, 2018, the payment amount for such drug or biological under this subsection that is furnished during the period beginning on October 1, 2018, and ending on March 31, 2019, shall be the greater of—

(i) the payment amount that would otherwise apply under subparagraph (D)(i) for such drug or biological during such period; or

(ii) the payment amount that applied under such subparagraph (D)(i) for such drug or biological on December 31, 2017.

(I) SPECIAL PAYMENT ADJUSTMENT RULES FOR LAST QUARTER OF 2018.—In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment amount for a covered OPD service (or group of services) beginning January 1, 2018, the following rules shall apply with respect to payment amounts under this subsection for covered a OPD service (or group of services) furnished during the period beginning on October 1, 2018, and ending on December 31, 2018:

(i) The Secretary shall remove the packaged costs of such drug or biological (as determined by the Secretary) from the payment amount under this subsection for the covered OPD service (or group of services) with which it is packaged.

(ii) The Secretary shall not make any adjustments to payment amounts under this subsection for a covered OPD service (or group of services) for which no costs were removed under clause (i).

(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) BEFORE 2002.—Subject to subparagraph (D), for covered OPD services furnished before January 1, 2002, for which the PPS amount (as defined in subparagraph (E)) is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in subparagraph (F)), the amount of payment under this subsection shall be increased by 80 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.71 and the pre-BBA amount, exceeds (II) the product of 0.70 and the PPS amount;

(iii) at least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by which (I) the product of 0.63 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iv) less than 70 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 21 percent of the pre-BBA amount.

(B) 2002.—Subject to subparagraph (D), for covered OPD services furnished during 2002, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 70 percent of the amount of such difference;

(ii) at least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount by

which (I) the product of 0.61 and the pre-BBA amount, exceeds (II) the product of 0.60 and the PPS amount; or

(iii) less than 80 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 13 percent of the pre-BBA amount.

(C) 2003.—Subject to subparagraph (D), for covered OPD services furnished during 2003, for which the PPS amount is—

(i) at least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this subsection shall be increased by 60 percent of the amount of such difference; or

(ii) less than 90 percent of the pre-BBA amount, the amount of payment under this subsection shall be increased by 6 percent of the pre-BBA amount.

(D) HOLD HARMLESS PROVISIONS.—

(i) TEMPORARY TREATMENT FOR CERTAIN RURAL HOSPITALS.—(I) In the case of a hospital located in a rural area and that has not more than 100 beds or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished before January 1, 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008, 2009, 2010, 2011, or 2012.

(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2013, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by 85 percent of the amount of such difference. In the case of covered OPD services furnished on or after January 1, 2010, and before March 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.

(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—In the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B),

for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

(E) PPS AMOUNT DEFINED.—In this paragraph, the term "PPS amount" means, with respect to covered OPD services, the amount payable under this title for such services (determined without regard to this paragraph), including amounts payable as copayment under paragraph (8), coinsurance under section 1866(a)(2)(A)(ii), and the deductible under section 1833(b).

(F) PRE-BBA AMOUNT DEFINED.—

(i) IN GENERAL.—In this paragraph, the "pre-BBA amount" means, with respect to covered OPD services furnished by a hospital in a year, an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base OPD payment-to-cost ratio for the hospital (as defined in clause (ii)).

(ii) BASE PAYMENT-TO-COST-RATIO DEFINED.—For purposes of this subparagraph, the "base payment-to-cost ratio" for a hospital means the ratio of—

(I) the hospital's reimbursement under this part for covered OPD services furnished during the cost reporting period ending in 1996 (or in the case of a hospital that did not submit a cost report for such period, during the first subsequent cost reporting period ending before 2001 for which the hospital submitted a cost report), including any reimbursement for such services through cost-sharing described in subparagraph (E), to

(II) the reasonable cost of such services for such period.

The Secretary shall determine such ratios as if the amendments made by section 4521 of the Balanced Budget Act of 1997 were in effect in 1996.

(G) INTERIM PAYMENTS.—The Secretary shall make payments under this paragraph to hospitals on an interim basis, subject to retrospective adjustments based on settled cost reports.

(H) NO EFFECT ON COPAYMENTS.—Nothing in this paragraph shall be construed to affect the unadjusted copayment amount described in paragraph (3)(B) or the copayment amount under paragraph (8).

(I) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The additional payments made under this paragraph—

(i) shall not be considered an adjustment under paragraph (2)(E); and

(ii) shall not be implemented in a budget neutral manner.

(8) COPAYMENT AMOUNT.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the copayment amount under this subsection

is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) LIMITATION ON COPAYMENT AMOUNT.—

(i) TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT.—In no case shall the copayment amount for a procedure performed in a year exceed the amount of the inpatient hospital deductible established under section 1813(b) for that year.

(ii) TO SPECIFIED PERCENTAGE.—The Secretary shall reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed the following percentage:

(I) For procedures performed in 2001, on or after April 1, 2001, 57 percent.

(II) For procedures performed in 2002 or 2003, 55 percent.

(III) For procedures performed in 2004, 50 percent.

(IV) For procedures performed in 2005, 45 percent.

(V) For procedures performed in 2006 and thereafter, 40 percent.

(D) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(E) COMPUTATION IGNORING OUTLIER AND PASS-THROUGH ADJUSTMENTS.—The copayment amount shall be computed under subparagraph (A) as if the adjustments under paragraphs (5) and (6) (and any adjustment made under paragraph (2)(E) in relation to such adjustments) had not occurred.

(9) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

(A) PERIODIC REVIEW.—The Secretary shall review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in

medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. Such panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting such review.

(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made. In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).

(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(10) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1861(v)(1)(U), or, if applicable, the fee schedule established under section 1834(l).

(11) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in clause (iii) or (v) of section 1886(d)(1)(B)—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(12) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6);

(D) the establishment of a separate conversion factor under paragraph (8)(B); and

(E) the determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under paragraph (5) or the determination of insignificance of cost, the duration of the additional payments, the determination and deletion of initial and new categories (consistent with subparagraphs (B) and (C) of paragraph (6)), the portion of the medicare OPD fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under paragraph (6).

(13) AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.

(14) DRUG APC PAYMENT RATES.—

(A) IN GENERAL.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

(i) in 2004, in the case of—

(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

(ii) in 2005, in the case of—

(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD

services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

(i) IN GENERAL.—In this paragraph, the term "specified covered outpatient drug" means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

(I) a radiopharmaceutical; or

(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

(ii) EXCEPTION.—Such term does not include—

(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

(C) PAYMENT FOR DESIGNATED ORPHAN DRUGS DURING 2004 AND 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

(D) ACQUISITION COST SURVEY FOR HOSPITAL OUTPATIENT DRUGS.—

(i) ANNUAL GAO SURVEYS IN 2004 AND 2005.—

(I) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

(II) RECOMMENDATIONS.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

(ii) SUBSEQUENT SECRETARIAL SURVEYS.—The Secretary, taking into account such recommendations,

shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

(iii) SURVEY REQUIREMENTS.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

(iv) DIFFERENTIATION IN COST.—In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

(v) COMMENT ON PROPOSED RATES.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

(i) MEDPAC REPORT ON DRUG APC DESIGN.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

(I) a description and analysis of the data available with regard to such expenses;

(II) a recommendation as to whether such a payment adjustment should be made; and

(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

(ii) ADJUSTMENT AUTHORIZED.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

(F) CLASSES OF DRUGS.—For purposes of this paragraph:

(i) SOLE SOURCE DRUGS.—The term "sole source drug" means—

(I) a biological product (as defined under section 1861(t)(1)); or

(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—The term "innovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(ii).

(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term "noninnovator multiple source drug" has the meaning given such term in section 1927(k)(7)(A)(iii).

(G) REFERENCE AVERAGE WHOLESALE PRICE.—The term "reference average wholesale price" means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER ADJUSTMENT FACTORS.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

(15) PAYMENT FOR NEW DRUGS AND BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.

(16) MISCELLANEOUS PROVISIONS.—

(A) APPLICATION OF RECLASSIFICATION OF CERTAIN HOSPITALS.—If a hospital is being treated as being located in a rural area under section 1886(d)(8)(E), that hospital shall be treated under this subsection as being located in that rural area.

(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.

(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2010, and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before January 1, 2010, the payment basis for the device or therapeutic radiopharmaceutical under this subsection shall be equal to the hospital's charges for each device or therapeutic radiopharmaceutical furnished, adjusted to cost. Charges for such devices or therapeutic radiopharmaceuticals shall not be in-

cluded in determining any outlier payment under this subsection.

(D) SPECIAL PAYMENT RULE.—

(i) IN GENERAL.—In the case of covered OPD services furnished on or after April 1, 2013, in a hospital described in clause (ii), if—

(I) the payment rate that would otherwise apply under this subsection for stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session that is multisource Cobalt 60 based (identified as of January 1, 2013, by HCPCS code 77371 (and any succeeding code) and reimbursed as of such date under APC 0127 (and any succeeding classification group)); exceeds

(II) the payment rate that would otherwise apply under this subsection for linear accelerator based stereotactic radiosurgery, complete course of therapy in one session (identified as of January 1, 2013, by HCPCS code G0173 (and any succeeding code) and reimbursed as of such date under APC 0067 (and any succeeding classification group)),

the payment rate for the service described in subclause (I) shall be reduced to an amount equal to the payment rate for the service described in subclause (II).

(ii) HOSPITAL DESCRIBED.—A hospital described in this clause is a hospital that is not—

(I) located in a rural area (as defined in section 1886(d)(2)(D));

(II) classified as a rural referral center under section 1886(d)(5)(C); or

(III) a sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

(iii) NOT BUDGET NEUTRAL.—In making any budget neutrality adjustments under this subsection for 2013 (with respect to covered OPD services furnished on or after April 1, 2013, and before January 1, 2014) or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(q).

(F) PAYMENT INCENTIVE FOR THE TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY.—Notwithstanding the previous provisions of this subsection:

(i) LIMITATION ON PAYMENT FOR FILM X-RAY IMAGING SERVICES.—In the case of an imaging service that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this para-

graph and before application of any other adjustment under this subsection) for such year shall be reduced by 20 percent.

(ii) PHASED-IN LIMITATION ON PAYMENT FOR COMPUTED RADIOGRAPHY IMAGING SERVICES.—In the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1848(b)(9)(C))—

(I) in the case of such a service furnished during 2018, 2019, 2020, 2021, or 2022, the payment amount for such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) 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 such service (including the X-ray component of a packaged service) that would otherwise be determined under this section (without application of this paragraph and before application of any other adjustment under this subsection) for such year shall be reduced by 10 percent.

(iii) APPLICATION WITHOUT REGARD TO BUDGET NEUTRALITY.—The reductions made under this subparagraph—

(I) shall not be considered an adjustment under paragraph (2)(E); and

(II) shall not be implemented in a budget neutral manner.

(iv) IMPLEMENTATION.—In order to implement this subparagraph, the Secretary shall adopt appropriate mechanisms which may include use of modifiers.

(17) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

(ii) NON-CUMULATIVE APPLICATION.—A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

(B) FORM AND MANNER OF SUBMISSION.—Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and

at a time, specified by the Secretary for purposes of this paragraph.

(C) DEVELOPMENT OF OUTPATIENT MEASURES.—

(i) IN GENERAL.—The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(ii) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii).

(D) REPLACEMENT OF MEASURES.—For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(E) AVAILABILITY OF DATA.—The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall, subject to subparagraph (C), provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

(C) TARGET PCR ADJUSTMENT.—In applying section 419.43(i) of title 42 of the Code of Federal Regulations to implement the appropriate adjustment under this para-

graph for services furnished on or after January 1, 2018, the Secretary shall use a target PCR that is 1.0 percentage points less than the target PCR that would otherwise apply. In addition to the percentage point reduction under the previous sentence, the Secretary may consider making an additional percentage point reduction to such target PCR that takes into account payment rates for applicable items and services described in paragraph (21)(C) other than for services furnished by hospitals described in section 1886(d)(1)(B)(v). In making any budget neutrality adjustments under this subsection for 2018 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

(19) FLOOR ON AREA WAGE ADJUSTMENT FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

(A) IN GENERAL.—Subject to subparagraph (B), with respect to covered OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under this subsection to any hospital outpatient department which is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) LIMITATION.—This paragraph shall not apply to any hospital outpatient department located in a State that receives a non-labor related share adjustment under section 1886(d)(5)(H).

(20) NOT BUDGET NEUTRAL APPLICATION OF REDUCED EXPENDITURES RESULTING FROM QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—The Secretary shall not take into account the reduced expenditures that result from the application of section 1834(p) in making any budget neutrality adjustments this subsection.

(21) SERVICES FURNISHED BY AN OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(A) APPLICABLE ITEMS AND SERVICES.—For purposes of paragraph (1)(B)(v) and this paragraph, the term "applicable items and services" means items and services other than items and services furnished by a dedicated emergency department (as defined in section 489.24(b) of title 42 of the Code of Federal Regulations).

(B) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(i) IN GENERAL.—For purposes of paragraph (1)(B)(v) and this paragraph, subject to the subsequent provisions of this subparagraph, the term "off-campus outpatient department of a provider" means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect as of the date of the enactment of this paragraph) that is not located—

(I) on the campus (as defined in such section 413.65(a)(2)) of such provider; or

(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2)).

(ii) EXCEPTION.—For purposes of paragraph (1)(B)(v) and this paragraph, the term "off-campus outpatient department of a provider" shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to the date of the enactment of this paragraph.

(iii) DEEMED TREATMENT FOR 2017.—For purposes of applying clause (ii) with respect to applicable items and services furnished during 2017, a department of a provider (as so defined) not described in such clause is deemed to be billing under this subsection with respect to covered OPD services furnished prior to November 2, 2015, if the Secretary received from the provider prior to December 2, 2015, an attestation (pursuant to section 413.65(b)(3) of title 42 of the Code of Federal Regulations) that such department was a department of a provider (as so defined).

(iv) ALTERNATIVE EXCEPTION BEGINNING WITH 2018.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2018 or a subsequent year, the term "off-campus outpatient department of a provider" also shall not include a department of a provider (as so defined) that is not described in clause (ii) if—

(I) the Secretary receives from the provider an attestation (pursuant to such section 413.65(b)(3)) not later than December 31, 2016 (or, if later, 60 days after the date of the enactment of this clause), that such department met the requirements of a department of a provider specified in section 413.65 of title 42 of the Code of Federal Regulations;

(II) the provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under section 1866(j); and

(III) the department met the mid-build requirement of clause (v) and the Secretary receives, not later than 60 days after the date of the enactment of this clause, from the chief executive officer or chief operating officer of the provider a written certification that the department met such requirement.

(v) MID-BUILD REQUIREMENT DESCRIBED.—The mid-build requirement of this clause is, with respect to a department of a provider, that before November 2, 2015, the provider had a binding written agreement

with an outside unrelated party for the actual construction of such department.

(vi) EXCLUSION FOR CERTAIN CANCER HOSPITALS.—For purposes of paragraph (1)(B)(v) and this paragraph with respect to applicable items and services furnished during 2017 or a subsequent year, the term "off-campus outpatient department of a provider" also shall not include a department of a provider (as so defined) that is not described in clause (ii) if the provider is a hospital described in section 1886(d)(1)(B)(v) and—

(I) in the case of a department that met the requirements of section 413.65 of title 42 of the Code of Federal Regulations after November 1, 2015, and before the date of the enactment of this clause, the Secretary receives from the provider an attestation that such department met such requirements not later than 60 days after such date of enactment; or

(II) in the case of a department that meets such requirements after such date of enactment, the Secretary receives from the provider an attestation that such department meets such requirements not later than 60 days after the date such requirements are first met with respect to such department.

(vii) AUDIT.—Not later than December 31, 2018, the Secretary shall audit the compliance with requirements of clause (iv) with respect to each department of a provider to which such clause applies. Not later than 2 years after the date the Secretary receives an attestation under clause (vi) relating to compliance of a department of a provider with requirements referred to in such clause, the Secretary shall audit the compliance with such requirements with respect to the department. If the Secretary finds as a result of an audit under this clause that the applicable requirements were not met with respect to such department, the department shall not be excluded from the term "off-campus outpatient department of a provider" under such clause.

(viii) IMPLEMENTATION.—For purposes of implementing clauses (iii) through (vii):

(I) Notwithstanding any other provision of law, the Secretary may implement such clauses by program instruction or otherwise.

(II) Subchapter I of chapter 35 of title 44, United States Code, shall not apply.

(III) For purposes of carrying out this subparagraph with respect to clauses (iii) and (iv) (and clause (vii) insofar as it relates to clause (iv)), $10,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to remain available until December 31, 2018. For purposes of carrying out this

subparagraph with respect to clause (vi) (and clause (vii) insofar as it relates to such clause), $2,000,000 shall be available from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to remain available until expended.

(C) AVAILABILITY OF PAYMENT UNDER OTHER PAYMENT SYSTEMS.—Payments for applicable items and services furnished by an off-campus outpatient department of a provider that are described in paragraph (1)(B)(v) shall be made under the applicable payment system under this part (other than under this subsection) if the requirements for such payment are otherwise met.

(D) INFORMATION NEEDED FOR IMPLEMENTATION.—Each hospital shall provide to the Secretary such information as the Secretary determines appropriate to implement this paragraph and paragraph (1)(B)(v) (which may include reporting of information on a hospital claim using a code or modifier and reporting information about off-campus outpatient departments of a provider on the enrollment form described in section 1866(j)).

(E) LIMITATIONS.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

(i) The determination of the applicable items and services under subparagraph (A) and applicable payment systems under subparagraph (C).

(ii) The determination of whether a department of a provider meets the term described in subparagraph (B).

(iii) Any information that hospitals are required to report pursuant to subparagraph (D).

(iv) The determination of an audit under subparagraph (B)(vii).

(22) REVIEW AND REVISIONS OF PAYMENTS FOR NON-OPIOID ALTERNATIVE TREATMENTS.—

(A) IN GENERAL.—With respect to payments made under this subsection for covered OPD services (or groups of services), including covered OPD services assigned to a comprehensive ambulatory payment classification, the Secretary—

(i) shall, as soon as practicable, conduct a review (part of which may include a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management (including drugs and devices, nerve blocks, surgical injections, and neuromodulation) with a goal of ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives;

(ii) may, as the Secretary determines appropriate, conduct subsequent reviews of such payments; and

(iii) shall consider the extent to which revisions under this subsection to such payments (such as the creation of additional groups of covered OPD services to classify separately those procedures that utilize

opioids and non-opioid alternatives for pain management) would reduce payment incentives to use opioids instead of non-opioid alternatives for pain management.

(B) PRIORITY.—In conducting the review under clause (i) of subparagraph (A) and considering revisions under clause (iii) of such subparagraph, the Secretary shall focus on covered OPD services (or groups of services) assigned to a comprehensive ambulatory payment classification, ambulatory payment classifications that primarily include surgical services, and other services determined by the Secretary which generally involve treatment for pain management.

(C) REVISIONS.—If the Secretary identifies revisions to payments pursuant to subparagraph (A)(iii), the Secretary shall, as determined appropriate, begin making such revisions for services furnished on or after January 1, 2020. Revisions under the previous sentence shall be treated as adjustments for purposes of application of paragraph (9)(B).

(D) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed to preclude the Secretary—

(i) from conducting a demonstration before making the revisions described in subparagraph (C); or

(ii) prior to implementation of this paragraph, from changing payments under this subsection for covered OPD services (or groups of services) which include opioids or non-opioid alternatives for pain management.

(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before July 1, 2008—

(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

(i) primary care physicians; or

(ii) physicians who are not primary care physicians.

(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as "individuals").

(C) DETERMINATION OF RATIOS.—

(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the "primary care ratio") of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the "specialist care ratio") of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

(4) IDENTIFICATION OF COUNTIES.—

(A) IN GENERAL.—The Secretary shall identify—

(i) those counties and areas (in this paragraph referred to as "primary care scarcity counties") with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

(ii) those counties and areas (in this subsection referred to as "specialist care scarcity counties") with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

(D) SPECIAL RULE.—With respect to physicians' services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty

care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians' services furnished on December 31, 2007.

(E) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

116.(i) the identification of a county or area;

(ii) the assignment of a specialty of any physician under this paragraph;

(iii) the assignment of a physician to a county under paragraph (2); or

(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.

(v) INCREASE OF FQHC PAYMENT LIMITS.—In the case of services furnished by Federally qualified health centers (as defined in section 1861(aa)(4)), the Secretary shall establish payment limits with respect to such services under this part for services furnished—

(1) in 2010, at the limits otherwise established under this part for such year increased by $5; and

(2) in a subsequent year, at the limits established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

(w) METHODS OF PAYMENT.—The Secretary may develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary, to those that would otherwise apply under this section, to the extent such alternative methods are necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity

of interventions from patients and investigators is necessary to comply with the particular trial or study design.

(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) PRIMARY CARE PRACTITIONER.—The term "primary care practitioner" means an individual—

(i) who—

(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) PRIMARY CARE SERVICES.—The term "primary care services" means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

(i) 99201 through 99215.

(ii) 99304 through 99340.

(iii) 99341 through 99350.

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.

(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a

monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) GENERAL SURGEON.—In this subsection, the term "general surgeon" means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's enrollment under section 1866(j).

(B) MAJOR SURGICAL PROCEDURES.—The term "major surgical procedures" means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively. The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.

(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

(1) PAYMENT INCENTIVE.—

(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

(D) COORDINATION.—The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term "qualifying APM participant" means the following:

(A) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(B) 2021 AND 2022.—With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(C) BEGINNING IN 2023.—With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which

data are available (which may be less than a year), that at least 75 percent of the sum of—

(aa) payments described in clause (i); and

(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

(bb) certified EHR technology is used; and

(cc) the eligible professional participates in an entity that—

(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

(D) USE OF PATIENT APPROACH.—The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of

using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

(3) ADDITIONAL DEFINITIONS.—In this subsection:

(A) COVERED PROFESSIONAL SERVICES.—The term "covered professional services" has the meaning given that term in section 1848(k)(3)(A).

(B) ELIGIBLE PROFESSIONAL.—The term "eligible professional" has the meaning given that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

(C) ALTERNATIVE PAYMENT MODEL (APM).—The term "alternative payment model" means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

(i) A model under section 1115A (other than a health care innovation award).

(ii) The shared savings program under section 1899.

(iii) A demonstration under section 1866C.

(iv) A demonstration required by Federal law.

(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.—The term "eligible alternative payment entity" means, with respect to a year, an entity that—

(i) participates in an alternative payment model that—

(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

(II) is a medical home expanded under section 1115A(c).

(4) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an entity is an eligible alternative payment entity under paragraph (3)(D).

(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.

(aa) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—

(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—

(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and

(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

(2) MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION MEDICAL REVIEW.—The Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

(iii) EARLY REQUEST FOR PRIOR AUTHORIZATION REVIEW PERMITTED.—Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

(B) TYPE OF REVIEW.—The Secretary may use pre-payment review or post-payment review of services described in section 1861(r)(5) that are not subject to prior authorization medical review under subparagraph (A).

(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section 1862(a)(1)(A).

(4) SUBMISSION OF INFORMATION.—A chiropractor described in section 1861(r)(5) may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

(5) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

(6) APPLICATION OF LIMITATION ON BENEFICIARY LIABILITY.—Where payment may not be made as a result of the application of paragraph (2)(B), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

(7) REVIEW BY CONTRACTORS.—The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1874A(a)(4)(G) or by any other contractor determined appropriate by the Secretary that is not a recovery audit contractor.

(8) MULTIPLE SERVICES.—The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.

(10) IMPLEMENTATION.—

(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.

(bb) ADDITIONAL PAYMENTS FOR CERTAIN RURAL HEALTH CLINICS WITH PHYSICIANS OR PRACTITIONERS RECEIVING DATA 2000 WAIVERS.—

(1) IN GENERAL.—In the case of a rural health clinic with respect to which, beginning on or after January 1, 2019, rural health clinic services (as defined in section 1861(aa)(1)) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in paragraph (3), the Secretary shall, subject to availability of funds under paragraph (4), make a payment (at such time and in such manner as specified by the Secretary) to such rural

health clinic after receiving and approving an application described in paragraph (2). Such payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in paragraph (3)(B). Such payment may be made only one time with respect to each such physician or practitioner.

(2) APPLICATION.—In order to receive a payment described in paragraph (1), a rural health clinic shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A rural health clinic may apply for such a payment for each physician or practitioner described in paragraph (1) furnishing services described in such paragraph at such clinic.

(3) REQUIREMENTS.—For purposes of paragraph (1), the requirements described in this paragraph, with respect to a physician or practitioner, are the following:

(A) The physician or practitioner is employed by or working under contract with a rural health clinic described in paragraph (1) that submits an application under paragraph (2).

(B) The physician or practitioner first receives a waiver under section 303(g) of the Controlled Substances Act on or after January 1, 2019.

(4) FUNDING.—For purposes of making payments under this subsection, there are appropriated, out of amounts in the Treasury not otherwise appropriated, $2,000,000, which shall remain available until expended.

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—Subject to subparagraph (F)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item, or

(ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item;

except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(C) EXCLUSIVE PAYMENT RULE.—Subject to subparagraph (F)(ii), this subsection shall constitute the exclusive provision of this title for payment for covered items under this part or under part A to a home health agency.

(D) REDUCTION IN FEE SCHEDULES FOR CERTAIN ITEMS.—With respect to a seat-lift chair or transcutaneous elec-

trical nerve stimulator furnished on or after April 1, 1990, the Secretary shall reduce the payment amount applied under subparagraph (B)(ii) for such an item by 15 percent, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 45 percent.

(E) CLINICAL CONDITIONS FOR COVERAGE.—

(i) IN GENERAL.—The Secretary shall establish standards for clinical conditions for payment for covered items under this subsection.

(ii) REQUIREMENTS.—The standards established under clause (i) shall include the specification of types or classes of covered items that require, as a condition of payment under this subsection, a face-to-face examination of the individual by a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) and a prescription for the item.

(iii) PRIORITY OF ESTABLISHMENT OF STANDARDS.—In establishing the standards under this subparagraph, the Secretary shall first establish standards for those covered items for which the Secretary determines there has been a proliferation of use, consistent findings of charges for covered items that are not delivered, or consistent findings of falsification of documentation to provide for payment of such covered items under this part.

(iv) STANDARDS FOR POWER WHEELCHAIRS.—Effective on the date of the enactment of this subparagraph, in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

(v) LIMITATION ON PAYMENT FOR COVERED ITEMS.—Payment may not be made for a covered item under this subsection unless the item meets any standards established under this subparagraph for clinical condition of coverage.

(F) APPLICATION OF COMPETITIVE ACQUISITION; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items furnished on or after January 1, 2011, subject to subparagraphs (G) and (H), that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;

(ii) the Secretary may (and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall) use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied; and

(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary shall continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).

(G) USE OF INFORMATION ON COMPETITIVE BID RATES.—The Secretary shall specify by regulation the methodology to be used in applying the provisions of subparagraph (F)(ii) and subsection (h)(1)(H)(ii). In promulgating such regulation, the Secretary shall consider the costs of items and services in areas in which such provisions would be applied compared to the payment rates for such items and services in competitive acquisition areas.In the case of items and services furnished on or after January 1, 2019, in making any adjustments under clause (ii) or (iii) of subparagraph (F), under subsection (h)(1)(H)(ii), or under section 1842(s)(3)(B), the Secretary shall—

(i) solicit and take into account stakeholder input; and

(ii) take into account the highest amount bid by a winning supplier in a competitive acquisition area and a comparison of each of the following with respect to non-competitive acquisition areas and competitive acquisition areas:

(I) The average travel distance and cost associated with furnishing items and services in the area.

(II) The average volume of items and services furnished by suppliers in the area.

(III) The number of suppliers in the area.

(H) DIABETIC SUPPLIES.—

(i) IN GENERAL.—On or after the date described in clause (ii), the payment amount under this part for diabetic supplies, including testing strips, that are non-mail order items (as defined by the Secretary) shall be equal to the single payment amounts established under the national mail order competition for diabetic supplies under section 1847.

(ii) DATE DESCRIBED.—The date described in this clause is the date of the implementation of the single payment amounts under the national mail order competition for diabetic supplies under section 1847.

(I) TREATMENT OF VACUUM ERECTION SYSTEMS.—Effective for items and services furnished on and after July 1,

2015, vacuum erection systems described as prosthetic devices described in section 1861(s)(8) shall be treated in the same manner as erectile dysfunction drugs are treated for purposes of section 1860D-2(e)(2)(A).

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

(A) IN GENERAL.—Payment for an item of durable medical equipment (as defined in paragraph (13))—

(i) the purchase price of which does not exceed $150,

(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase,

(iii) which is an accessory used in conjunction with a nebulizer, aspirator, or a ventilator excluded under paragraph (3)(A), or

(iv) in the case of devices furnished on or after October 1, 2015, which serves as a speech generating device or which is an accessory that is needed for the individual to effectively utilize such a device,

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the purchase or rental, respectively, of the item for the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year (reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes).

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994 the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(3) PAYMENT FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—

(A) IN GENERAL.—Payment for a covered item (such as IPPB machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

(i) in 1989 and in 1990 is the average reasonable charge in the area for the rental of the item or device for the 12-month period ending with June 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987;

(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.

(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

(i) the local payment amount for an item or device for a year is equal to—

(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

(II) for 1992, 1993, and 1994 the amount determined under this clause for the preceding year increased by the covered item update for the year; and

(ii) the national limited payment amount for an item or device for a year is equal to—

(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item,

(II) for 1992 and 1993, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year,

(III) for 1994, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the median of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the median of

all local payment amounts determined under such clause for such item or device for that year, and

(IV) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year.

(4) PAYMENT FOR CERTAIN CUSTOMIZED ITEMS.—Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient, and for that reason cannot be grouped with similar items for purposes of payment under this title, shall be made in a lump-sum amount (A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item. In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician.

(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

(A) IN GENERAL.—Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B), (C), (E), and (F).

(B) ADD-ON FOR PORTABLE OXYGEN EQUIPMENT.—When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment amount recognized under paragraph (9) for portable oxygen equipment.

(C) VOLUME ADJUSTMENT.—When the attending physician prescribes an oxygen flow rate—

(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

(D) LIMIT ON ADJUSTMENT.—When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

(E) RECERTIFICATION FOR PATIENTS RECEIVING HOME OXYGEN THERAPY.—In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 56 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services.

(F) RENTAL CAP.—

(i) IN GENERAL.—Payment for oxygen equipment (including portable oxygen equipment) under this paragraph may not extend over a period of continuous use (as determined by the Secretary) of longer than 36 months.

(ii) PAYMENTS AND RULES AFTER RENTAL CAP.—After the 36th continuous month during which payment is made for the equipment under this paragraph—

(I) the supplier furnishing such equipment under this subsection shall continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary;

(II) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

(III) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(6) PAYMENT FOR OTHER COVERED ITEMS (OTHER THAN DURABLE MEDICAL EQUIPMENT).—Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) PAYMENT.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

(i) RENTAL.—

(I) IN GENERAL.—Except as provided in clause (iii), payment for the item shall be made on a monthly basis for the rental of the item during the

period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

(II) PAYMENT AMOUNT.—Subject to subclause (III) and subparagraph (B), the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price.

(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting "15 percent" and "6 percent" for "10 percent" and "7.5 percent", respectively.

(ii) OWNERSHIP AFTER RENTAL.—On the first day that begins after the 13th continuous month during which payment is made for the rental of an item under clause (i), the supplier of the item shall transfer title to the item to the individual.

(iii) PURCHASE AGREEMENT OPTION FOR COMPLEX, REHABILITATIVE POWER-DRIVEN WHEELCHAIRS.—In the case of a complex, rehabilitative power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

(iv) MAINTENANCE AND SERVICING.—After the supplier transfers title to the item under clause (ii) or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii), maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

(B) RANGE FOR RENTAL AMOUNTS.—

(i) FOR 1989.—For items furnished during 1989, the payment amount recognized under subparagraph (A)(i) shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item in January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987.

(ii) FOR 1990.—For items furnished during 1990, clause (i) shall apply in the same manner as it applies to items furnished during 1989.

(C) REPLACEMENT OF ITEMS.—

(i) ESTABLISHMENT OF REASONABLE USEFUL LIFETIME.—In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph.

(ii) PAYMENT FOR REPLACEMENT ITEMS.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(iii), in a lump-sum amount for the purchase of the item.

(iii) LENGTH OF REASONABLE USEFUL LIFETIME.—The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.

(8) PURCHASE PRICE RECOGNIZED FOR MISCELLANEOUS DEVICES AND ITEMS.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price, for each item described—

(I) in paragraph (6) equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period ending with December 1986.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S.

city average) for the 6-month period ending with December 1987,

(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; or

(III) in 1992, 1993, and 1994 equal to the local purchase price computed under this clause for the previous year increased by the covered item update for the year.

(B) COMPUTATION OF NATIONAL LIMITED PURCHASE PRICE.—With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the median of all local purchase prices computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local purchase prices computed under such subparagraph for the item for the year; and

(iv) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

(ii) in 1991, is the sum of (I) 67 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 33 percent of the national limited purchase price computed under subparagraph (B) for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local purchase price computed under subparagraph (A)(ii)(III) for 1992, and (II) 67 percent of the national limited purchase price computed under subparagraph (B) for 1992; and

(iv) in 1993 or a subsequent year, is the national limited purchase price computed under subparagraph (B) for that year.

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) COMPUTATION OF LOCAL MONTHLY PAYMENT RATE.—Each carrier under this section shall compute a base local payment rate for each item as follows:

(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item during the 12-month period ending with December 1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this title.

(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

(I) to 1989 and 1990, equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

(II) to 1991, 1992, 1993, and 1994 equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the covered item increase for the year.

(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates

computed for the item under such subparagraph for the year;

(ii) for 1992 and 1993, the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(iii) for 1994, the local monthly payment rate computed under subparagraph (A)(ii) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year and may not be less than 85 percent of the median of all local monthly payment rates computed for the item under such subparagraph for the year;

(iv) for 1995, 1996, and 1997, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year;

(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; and

(iv) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year.

(10) EXCEPTIONS AND ADJUSTMENTS.—

(A) AREAS OUTSIDE CONTINENTAL UNITED STATES.—Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

(B) ADJUSTMENT FOR INHERENT REASONABLENESS.—The Secretary is authorized to apply the provisions of paragraphs (8) and (9) of section 1842(b) to covered items and suppliers of such items and payments under this sub-

section in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F).

(C) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS).—In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

(11) IMPROPER BILLING AND REQUIREMENT OF PHYSICIAN ORDER.—

(A) IMPROPER BILLING FOR CERTAIN RENTAL ITEMS.—Notwithstanding any other provision of this title, a supplier of a covered item for which payment is made under this subsection and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the maintenance and servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under section 1842(j)(2) in the same manner such sanctions may apply with respect to a physician.

(B) REQUIREMENT OF PHYSICIAN ORDER.—

(i) IN GENERAL.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j) has communicated to the supplier, before delivery of the item, a written order for the item.

(ii) REQUIREMENT FOR FACE TO FACE ENCOUNTER.—The Secretary shall require that such an order be written pursuant to a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter (including through use of telehealth under subsection (m) and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary.

(12) REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

(13) COVERED ITEM.—In this subsection, the term "covered item" means durable medical equipment (as defined in section

1861(n)), including such equipment described in section 1861(m)(5), but not including implantable items for which payment may be made under section 1833(t).

(14) COVERED ITEM UPDATE.—In this subsection, the term "covered item update" means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point;

(B) for 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year;

(C) for each of the years 1998 through 2000, 0 percentage points;

(D) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(E) for 2002, 0 percentage points;

(F) for 2003, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of 2002;

(G) for 2004 through 2006—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(H) for 2007—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage change determined by the Secretary to be appropriate taking into account recommendations contained in the report of the Comptroller General of the United States under section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(I) for 2008—

(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) (as applied to the payment amount for 2007 determined after the application of the percentage change under subparagraph (H)(i)); and

(ii) in the case of covered items not described in clause (i), 0 percentage points;

(J) for 2009—

(i) in the case of items and services furnished in any geographic area, if such items or services were se-

lected for competitive acquisition in any area under the competitive acquisition program under section 1847(a)(1)(B)(i)(I) before July 1, 2008, including related accessories but only if furnished with such items and services selected for such competition and diabetic supplies but only if furnished through mail order, - 9.5 percent; or

(ii) in the case of other items and services, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June 2008;

(K) for 2010, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year; and

(L) for 2011 and each subsequent year—

(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(15) ADVANCE DETERMINATIONS OF COVERAGE FOR CERTAIN ITEMS.—

(A) DEVELOPMENT OF LISTS OF ITEMS BY SECRETARY.—The Secretary may develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area.

(B) DEVELOPMENT OF LISTS OF SUPPLIERS BY SECRETARY.—The Secretary may develop and periodically update a list of suppliers of items for which payment may be made under this subsection with respect to whom—

(i) the Secretary has found that a substantial number of claims for payment under this part for items furnished by the supplier have been denied on the basis of the application of section 1862(a)(1); or

(ii) the Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

(C) DETERMINATIONS OF COVERAGE IN ADVANCE.—A carrier shall determine in advance of delivery of an item whether payment for the item may not be made because the item is not covered or because of the application of section 1862(a)(1) if—

(i) the item is included on the list developed by the Secretary under subparagraph (A);

(ii) the item is furnished by a supplier included on the list developed by the Secretary under subparagraph (B); or

(iii) the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests that such advance determination be made.

(16) DISCLOSURE OF INFORMATION AND SURETY BOND.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

(A) with—

(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000 that the Secretary determines is commensurate with the volume of the billing of the supplier.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law. The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1842(b)(18)(C)) who furnish items or services under this part.

(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual unless 1 of the following applies:

(i) The individual has given written permission to the supplier to make contact by telephone regarding the furnishing of a covered item.

(ii) The supplier has furnished a covered item to the individual and the supplier is contacting the individual only regarding the furnishing of such covered item.

(iii) If the contact is regarding the furnishing of a covered item other than a covered item already furnished to the individual, the supplier has furnished at least 1 covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.

(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

(D) TIMELY BASIS DEFINED.—A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.

(19) CERTAIN UPGRADED ITEMS.—

(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

(C) CONSUMER PROTECTION SAFEGUARDS.—Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

(i) determination of fair market prices with respect to an upgraded item;

(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

(iii) conditions of participation for suppliers in the billing arrangement;

(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

(v) such other safeguards as the Secretary determines are necessary.

(20) IDENTIFICATION OF QUALITY STANDARDS.—

(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for suppliers of items and services described in subparagraph (D) to be applied by recognized independent accreditation organizations (as designated under subparagraph (B)) and with which such suppliers shall be required to comply in order to—

(i) furnish any such item or service for which payment is made under this part; and

(ii) receive or retain a provider or supplier number used to submit claims for reimbursement for any such

item or service for which payment may be made under this title.

(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—Not later than the date that is 1 year after the date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding section 1865(a), the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services, as the Secretary determines appropriate:

(i) Covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection.

(ii) Prosthetic devices and orthotics and prosthetics described in section 1834(h)(4).

(iii) Items and services described in section 1842(s)(2).

(E) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the quality standards under this paragraph, including subparagraph (F), after consultation with representatives of relevant parties. Such standards shall be applied prospectively and shall be published on the Internet website of the Centers for Medicare & Medicaid Services.

(F) APPLICATION OF ACCREDITATION REQUIREMENT.—In implementing quality standards under this paragraph—

(i) subject to clause (ii) and subparagraph (G), the Secretary shall require suppliers furnishing items and services described in subparagraph (D) on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted to the Secretary evidence of accreditation by an accreditation organization designated under subparagraph (B) as meeting applicable quality standards, except that the Secretary shall not require under this clause pharmacies to obtain such accreditation before January 1, 2010, except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation prior to January 1, 2011; and

(ii) in applying such standards and the accreditation requirement of clause (i) with respect to eligible professionals (as defined in section 1848(k)(3)(B)), and including such other persons, such as orthotists and prosthetists, as specified by the Secretary, furnishing such items and services—

(I) such standards and accreditation requirement shall not apply to such professionals and

persons unless the Secretary determines that the standards being applied are designed specifically to be applied to such professionals and persons; and

(II) the Secretary may exempt such professionals and persons from such standards and requirement if the Secretary determines that licensing, accreditation, or other mandatory quality requirements apply to such professionals and persons with respect to the furnishing of such items and services.

(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the

pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.

(21) SPECIAL PAYMENT RULE FOR SPECIFIED ITEMS AND SUPPLIES.—

(A) IN GENERAL.—Notwithstanding the preceding provisions of this subsection, for specified items and supplies (described in subparagraph (B)) furnished during 2005, the payment amount otherwise determined under this subsection for such specified items and supplies shall be reduced by the percentage difference between—

(i) the amount of payment otherwise determined for the specified item or supply under this subsection for 2002, and

(ii) the amount of payment for the specified item or supply under chapter 89 of title 5, United States Code, as identified in the column entitled "Median FEHP Price" in the table entitled "SUMMARY OF MEDICARE PRICES COMPARED TO VA, MEDICAID, RETAIL, AND FEHP PRICES FOR 16 ITEMS" included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

(B) SPECIFIED ITEM OR SUPPLY DESCRIBED.—For purposes of subparagraph (A), a specified item or supply means oxygen and oxygen equipment, standard wheelchairs (including standard power wheelchairs), nebulizers, diabetic supplies consisting of lancets and testing strips, hospital beds, and air mattresses, but only if the HCPCS code for the item or supply is identified in a table referred to in subparagraph (A)(ii).

(C) APPLICATION OF UPDATE TO SPECIAL PAYMENT AMOUNT.—The covered item update under paragraph (14) for specified items and supplies for 2006 and each subsequent year shall be applied to the payment amount under subparagraph (A) unless payment is made for such items and supplies under section 1847.

(22) SPECIAL PAYMENT RULE FOR DIABETIC SUPPLIES.—Notwithstanding the preceding provisions of this subsection, for purposes of determining the payment amount under this subsection for diabetic supplies furnished on or after the first day of the calendar quarter during 2013 that is at least 30 days after the date of the enactment of this paragraph and before the date described in paragraph (1)(H)(ii), the Secretary shall recalculate and apply the covered item update under paragraph (14) as if subparagraph (J)(i) of such paragraph was amended by striking "but only if furnished through mail order".

(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

(1) DEVELOPMENT.—The Secretary shall develop—

(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

(B) using such scale and appropriate conversion factors and subject to subsection (c)(1)(A), fee schedules (on a regional, statewide, locality, or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(3) CONSIDERATIONS.—In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

(4) SAVINGS.—

(A) BUDGET NEUTRAL FEE SCHEDULES.—The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any coinsurance and deductibles under sections 1833(a)(1)(J) and 1833(b)) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

(B) INITIAL SAVINGS.—The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permitted under these preliminary fee schedules developed under subparagraph (A).

(C) 1990 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1990, after March 31 of such year, the conversion factors used under this subsection shall be 96 percent of the conversion factors that applied under this subsection as of December 31, 1989.

(D) 1991 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall, subject to clause (vii), be reduced to the adjusted conversion factor for the locality determined as follows:

(i) NATIONAL WEIGHTED AVERAGE CONVERSION FACTOR.—The Secretary shall estimate the national weighted average of the conversion factors used under

this subsection for services furnished during 1990 beginning on April 1, using the best available data.

(ii) REDUCED NATIONAL WEIGHTED AVERAGE.—The national weighted average estimated under clause (i) shall be reduced by 13 percent.

(iii) COMPUTATION OF 1990 LOCALITY INDEX RELATIVE TO NATIONAL AVERAGE.—The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

(iv) ADJUSTED CONVERSION FACTOR.—The adjusted conversion factor for the professional or technical component of a service in a locality is the sum of ½ of the locally-adjusted amount determined under clause (v) and ½ of the GPCI-adjusted amount determined under clause (vi).

(v) LOCALLY-ADJUSTED AMOUNT.—For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

(vi) GPCI-ADJUSTED AMOUNT.—For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

(vii) LIMITS ON CONVERSION FACTOR.—The conversion factor to be applied to a locality to the professional or technical component of a service shall not be reduced under this subparagraph by more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).

(E) RULE FOR CERTAIN SCANNING SERVICES.—In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.

(F) SUBSEQUENT UPDATING.—For radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year.

(G) NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in section 1842(b)(4)(A)(iv)) of the payment rate recognized for participating physicians and suppliers.

(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS AND SUPPLIERS.—

(A) IN GENERAL.—In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term "limiting charge" means, with respect to a service furnished—

(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

(C) ENFORCEMENT.—If a physician or supplier knowingly and willfully bills in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2) in the same manner as such sanctions may apply to a physician.

(6) RADIOLOGIST SERVICES DEFINED.—For the purposes of this subsection and section 1833(a)(1)(J), the term "radiologist services" only includes radiology services performed by, or under the direction or supervision of, a physician—

(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

(B) for whom radiology services account for at least 50 percent of the total amount of charges made under this part.

(c) PAYMENT AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) IN GENERAL.—With respect to expenses incurred for screening mammography (as defined in section 1861(jj)), payment may be made only—

(A) for screening mammography conducted consistent with the frequency permitted under paragraph (2); and

(B) if the screening mammography is conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act.

(2) FREQUENCY COVERED.—

(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

(i) no payment may be made under this part for screening mammography performed on a woman under 35 years of age;

(ii) payment may be made under this part for only one screening mammography performed on a woman over 34 years of age, but under 40 years of age; and

(iii) in the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

(B) REVISION OF FREQUENCY.—

(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection.

(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

(A) PAYMENT AMOUNT.—The payment amount for colorectal cancer screening tests consisting of screening fecal-occult blood tests is equal to the payment amount established for diagnostic fecal-occult blood tests under section 1833(h).

(B) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal-occult blood test—

(i) if the individual is under 50 years of age; or

(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1848 shall be consistent with payment under such section for similar or related services.

(B) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

(C) FACILITY PAYMENT LIMIT.—

(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part, and

(II) are performed in an ambulatory surgical center or hospital outpatient department,

payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable copayment, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

(i) if the individual is under 50 years of age; or

(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy or, in the case of an individual who is not at high risk for colorectal cancer, if the procedure is performed within the 119 months after a previous screening colonoscopy.

(3) SCREENING COLONOSCOPY.—

(A) FEE SCHEDULE.—With respect to colorectal cancer screening test consisting of a screening colonoscopy, payment under section 1848 shall be consistent with payment amounts under such section for similar or related services.

(B) PAYMENT LIMIT.—In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

(C) FACILITY PAYMENT LIMIT.—

(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

(I) in computing the amount of any applicable coinsurance, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy or for other individuals if the procedure is performed within the 119 months after a previous screening colonoscopy or within 47 months after a previous screening flexible sigmoidoscopy.

(e) ACCREDITATION REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING SERVICES.—

(1) IN GENERAL.—

(A) IN GENERAL.—Beginning with January 1, 2012, with respect to the technical component of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier, payment may only be made if such supplier is accredited by an accreditation organization designated by the Secretary under paragraph (2)(B)(i).

(B) ADVANCED DIAGNOSTIC IMAGING SERVICES DEFINED.—In this subsection, the term "advanced diagnostic imaging services" includes—

(i) diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography); and

(ii) such other diagnostic imaging services, including services described in section 1848(b)(4)(B) (excluding X-ray, ultrasound, and fluoroscopy), as specified by the Secretary in consultation with physician specialty organizations and other stakeholders.

(C) SUPPLIER DEFINED.—In this subsection, the term "supplier" has the meaning given such term in section 1861(d).

(2) ACCREDITATION ORGANIZATIONS.—

(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B)(i) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) Whether the organization has established a process for the timely integration of new advanced diagnostic imaging services into the organization's accreditation program.

(iii) Whether the organization uses random site visits, site audits, or other strategies for ensuring accredited suppliers maintain adherence to the criteria described in paragraph (3).

(iv) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

(v) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(vi) Such other factors as the Secretary determines appropriate.

(B) DESIGNATION.—Not later than January 1, 2010, the Secretary shall designate organizations to accredit suppliers furnishing the technical component of advanced diagnostic imaging services. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation or-

ganizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(3) CRITERIA FOR ACCREDITATION.—The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services for the purpose of accreditation of such supplier is specific to each imaging modality. Such criteria shall include—

(A) standards for qualifications of medical personnel who are not physicians and who furnish the technical component of advanced diagnostic imaging services;

(B) standards for qualifications and responsibilities of medical directors and supervising physicians, including standards that recognize the considerations described in paragraph (4);

(C) procedures to ensure that equipment used in furnishing the technical component of advanced diagnostic imaging services meets performance specifications;

(D) standards that require the supplier have procedures in place to ensure the safety of persons who furnish the technical component of advanced diagnostic imaging services and individuals to whom such services are furnished;

(E) standards that require the establishment and maintenance of a quality assurance and quality control program by the supplier that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by such supplier; and

(F) any other standards or procedures the Secretary determines appropriate.

(4) RECOGNITION IN STANDARDS FOR THE EVALUATION OF MEDICAL DIRECTORS AND SUPERVISING PHYSICIANS.—The standards described in paragraph (3)(B) shall recognize whether a medical director or supervising physician—

(A) in a particular specialty receives training in advanced diagnostic imaging services in a residency program;

(B) has attained, through experience, the necessary expertise to be a medical director or a supervising physician;

(C) has completed any continuing medical education courses relating to such services; or

(D) has met such other standards as the Secretary determines appropriate.

(5) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2010, by an accreditation organization designated by the Secretary under paragraph (2)(B) as of January 1, 2010, such supplier shall be considered to have been accredited by an or-

ganization designated by the Secretary under such paragraph as of January 1, 2012, for the remaining period such accreditation is in effect.

(f) REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES DURING 1991.—

(1) IN GENERAL.—For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

(2) LIMITATION.—The prevailing charge for the technical and professional components of an physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians' office.

(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services of a critical access hospital is equal to 101 percent of the reasonable costs of the hospital in providing such services, unless the hospital makes the election under paragraph (2).

(2) ELECTION OF COST-BASED HOSPITAL OUTPATIENT SERVICE PAYMENT PLUS FEE SCHEDULE FOR PROFESSIONAL SERVICES.—A critical access hospital may elect to be paid for outpatient critical access hospital services amounts equal to the sum of the following, less the amount that such hospital may charge as described in section 1866(a)(2)(A):

(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), 101 percent of the reasonable costs of the critical access hospital in providing such services.

(B) FEE SCHEDULE FOR PROFESSIONAL SERVICES.—With respect to professional services otherwise included within outpatient critical access hospital services, 115 percent of such amounts as would otherwise be paid under this part if such services were not included in outpatient critical access hospital services. Subsections (x) and (y) of section 1833 shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.

The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.

(3) DISREGARDING CHARGES.—The payment amounts under this subsection shall be determined without regard to the amount of the customary or other charge.

(4) TREATMENT OF CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under this part shall apply with respect to clinical diagnostic laboratory services furnished as an outpatient critical access hospital service. Nothing in this title shall be construed as providing for payment for clinical diagnostic laboratory services furnished as part of outpatient critical access hospital services, other than on the basis described in this subsection. For purposes of the preceding sentence and section 1861(mm)(3), clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access hospital, or in a skilled nursing facility or a clinic (including a rural health clinic) that is operated by a critical access hospital, at the time the specimen is collected.

(5) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—In determining the reasonable costs of outpatient critical access hospital services under paragraphs (1) and (2)(A), the Secretary shall recognize as allowable costs, amounts (as defined by the Secretary) for reasonable compensation and related costs for physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services but who are not present on the premises of the critical access hospital involved, and are not otherwise furnishing services covered under this title and are not on-call at any other provider or facility.

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) GENERAL RULE FOR PAYMENT.—

(A) IN GENERAL.—Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

(B) PAYMENT BASIS.—Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of—

(i) the actual charge for the item; or

(ii) the amount recognized under paragraph (2) as the purchase price for the item.

(C) EXCEPTION FOR CERTAIN PUBLIC HOME HEALTH AGENCIES.—Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

(D) EXCLUSIVE PAYMENT RULE.—Subject to subparagraph (H)(ii), this subsection shall constitute the exclusive provi-

sion of this title for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

(E) EXCEPTION FOR CERTAIN ITEMS.—Payment for ostomy supplies, tracheostomy supplies, and urologicals shall be made in accordance with subparagraphs (B) and (C) of section 1834(a)(2).

(F) SPECIAL PAYMENT RULES FOR CERTAIN PROSTHETICS AND CUSTOM-FABRICATED ORTHOTICS.—

(i) IN GENERAL.—No payment shall be made under this subsection for an item of custom-fabricated orthotics described in clause (ii) or for an item of prosthetics unless such item is—

(I) furnished by a qualified practitioner; and

(II) fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate.

(ii) DESCRIPTION OF CUSTOM-FABRICATED ITEM.—

(I) IN GENERAL.—An item described in this clause is an item of custom-fabricated orthotics that requires education, training, and experience to custom-fabricate and that is included in a list established by the Secretary in subclause (II). Such an item does not include shoes and shoe inserts.

(II) LIST OF ITEMS.—The Secretary, in consultation with appropriate experts in orthotics (including national organizations representing manufacturers of orthotics), shall establish and update as appropriate a list of items to which this subparagraph applies. No item may be included in such list unless the item is individually fabricated for the patient over a positive model of the patient.

(iii) QUALIFIED PRACTITIONER DEFINED.—In this subparagraph, the term "qualified practitioner" means a physician or other individual who—

(I) is a qualified physical therapist or a qualified occupational therapist;

(II) in the case of a State that provides for the licensing of orthotics and prosthetics, is licensed in orthotics or prosthetics by the State in which the item is supplied; or

(III) in the case of a State that does not provide for the licensing of orthotics and prosthetics, is specifically trained and educated to provide or manage the provision of prosthetics and custom-designed or -fabricated orthotics, and is certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide such prosthetics and orthotics.

(iv) QUALIFIED SUPPLIER DEFINED.—In this subparagraph, the term "qualified supplier" means any entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

(G) REPLACEMENT OF PROSTHETIC DEVICES AND PARTS.—

(i) IN GENERAL.—Payment shall be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the provision of a replacement device, or a replacement part of such a device, is necessary because of any of the following:

(I) A change in the physiological condition of the patient.

(II) An irreparable change in the condition of the device, or in a part of the device.

(III) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

(ii) CONFIRMATION MAY BE REQUIRED IF DEVICE OR PART BEING REPLACED IS LESS THAN 3 YEARS OLD.—If a physician determines that a replacement device, or a replacement part, is necessary pursuant to clause (i)—

(I) such determination shall be controlling; and

(II) such replacement device or part shall be deemed to be reasonable and necessary for purposes of section 1862(a)(1)(A);

except that if the device, or part, being replaced is less than 3 years old (calculated from the date on which the beneficiary began to use the device or part), the Secretary may also require confirmation of necessity of the replacement device or replacement part, as the case may be.

(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS*, EYEGLASSES, AND CONTACT LENSES*; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(C) of section 1847(a) furnished on or after January 1, 2009, *and of eyeglasses and contact lenses described in paragraph (2)(D) of such section,* subject to subsection (a)(1)(G), that are included in a competitive acquisition program in a competitive acquisition area under such section—

(i) the payment basis under this subsection for such orthotics *or such eyeglasses and contact lenses* furnished in such area shall be the payment basis determined under such competitive acquisition program; and

(ii) subject to subsection (a)(1)(G), the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.

(2) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 6-month period ending with December 1987, or

(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the applicable percentage increase for the year.

(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional

purchase price computed under subparagraph (B) for 1992;

(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

(3) APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.—Paragraphs (12) and (17) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

(4) DEFINITIONS.—In this subsection—

(A) the term "applicable percentage increase" means—

(i) for 1991, 0 percent;

(ii) for 1992 and 1993, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(iii) for 1994 and 1995, 0 percent;

(iv) for 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(v) for each of the years 1998 through 2000, 1 percent;

(vi) for 2001, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 2000;

(vii) for 2002, 1 percent;

(viii) for 2003, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ix) for 2004, 2005, and 2006, 0 percent;

(x) for for each of 2007 through 2010, the percentage increase in the consumer price index for all urban con-

sumers (United States city average) for the 12-month period ending with June of the previous year; and

(xi) for 2011 and each subsequent year—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(II) the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

(B) the term "prosthetic devices" has the meaning given such term in section 1861(s)(8), except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment and does not include an implantable item for which payment may be made under section 1833(t); and

(C) the term "orthotics and prosthetics" has the meaning given such term in section 1861(s)(9) (and includes shoes described in section 1861(s)(12)), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care) furnished by a home health agency under section 1861(m)(5).

The application of subparagraph (A)(xi)(II) may result in the applicable percentage increase under subparagraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.

(5) DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS.—For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1848(k)(3)(B).

(6) PAYMENT LIMITATIONS FOR EYEGLASSES AND CONTACT LENSES.—

(A) IN GENERAL.—With respect to eyeglasses and contact lenses furnished to an individual on or after January 1, 2022, subject to subparagraph (B), payment may be made under this part only—

(i) during a 2-year period, for either 1 pair of eyeglasses (including lenses and frames) or a 2-year supply that is provided in not more than 180-day increments of contact lenses;

(ii) with respect to amounts attributable to the frames of such a pair of eyeglasses and amounts attributable to contact lenses furnished during a year, in an amount not greater than—

(I) for 2022, $100; and

(II) for a subsequent year, the amount specified under this subparagraph for the previous year, increased by the percentage change in the consumer price index for all urban consumers during such previous year;

(iii) for types of eyeglass lenses, and for types of contact lenses, as determined appropriate by the Secretary;

(iv) if furnished pursuant to a written order of a physician described in section 1861(kkk); and

(v) if during the 2-year period described in clause (i), the individual did not already receive (as described in subparagraph (B)) one pair of conventional eyeglasses or contact lenses subsequent to a cataract surgery with insertion of an intraocular lens furnished during such period.

(B) EXCEPTION.—With respect to a 2-year period described in subparagraph (A)(i), in the case of an individual who receives cataract surgery with insertion of an intraocular lens, notwithstanding subparagraph (A), payment may be made under this part for one pair of conventional eyeglasses or contact lenses furnished subsequent to such cataract surgery during such period.

(i) PAYMENT FOR SURGICAL DRESSINGS.—

(1) IN GENERAL.—Payment under this subsection for surgical dressings (described in section 1861(s)(5)) shall be made in a lump sum amount for the purchase of the item in an amount equal to 80 percent of the lesser of—

(A) the actual charge for the item; or

(B) a payment amount determined in accordance with the methodology described in subparagraphs (B) and (C) of subsection (a)(2) (except that in applying such methodology, the national limited payment amount referred to in such subparagraphs shall be initially computed based on local payment amounts using average reasonable charges for the 12-month period ending December 31, 1992, increased by the covered item updates described in such subsection for 1993 and 1994).

(2) EXCEPTIONS.—Paragraph (1) shall not apply to surgical dressings that are—

(A) furnished as an incident to a physician's professional service; or

(B) furnished by a home health agency.

(j) REQUIREMENTS FOR SUPPLIERS OF MEDICAL EQUIPMENT AND SUPPLIES.—

(1) ISSUANCE AND RENEWAL OF SUPPLIER NUMBER.—

(A) PAYMENT.—Except as provided in subparagraph (C), no payment may be made under this part after the date of the enactment of the Social Security Act Amendments of 1994 for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number.

(B) STANDARDS FOR POSSESSING A SUPPLIER NUMBER.—A supplier may not obtain a supplier number unless—

(i) for medical equipment and supplies furnished on or after the date of the enactment of the Social Security Act Amendments of 1994 and before January 1, 1996, the supplier meets standards prescribed by the Secretary in regulations issued on June 18, 1992; and

(ii) for medical equipment and supplies furnished on or after January 1, 1996, the supplier meets revised standards prescribed by the Secretary (in consultation with representatives of suppliers of medical equipment and supplies, carriers, and consumers) that shall include requirements that the supplier—

(I) comply with all applicable State and Federal licensure and regulatory requirements;

(II) maintain a physical facility on an appropriate site;

(III) have proof of appropriate liability insurance; and

(IV) meet such other requirements as the Secretary may specify.

(C) EXCEPTION FOR ITEMS FURNISHED AS INCIDENT TO A PHYSICIAN'S SERVICE.—Subparagraph (A) shall not apply with respect to medical equipment and supplies furnished incident to a physician's service.

(D) PROHIBITION AGAINST MULTIPLE SUPPLIER NUMBERS.—The Secretary may not issue more than one supplier number to any supplier of medical equipment and supplies unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(E) PROHIBITION AGAINST DELEGATION OF SUPPLIER DETERMINATIONS.—The Secretary may not delegate (other than by contract under section 1842) the responsibility to determine whether suppliers meet the standards necessary to obtain a supplier number.

(2) CERTIFICATES OF MEDICAL NECESSITY.—

(A) LIMITATION ON INFORMATION PROVIDED BY SUPPLIERS ON CERTIFICATES OF MEDICAL NECESSITY.—

(i) IN GENERAL.—Effective 60 days after the date of the enactment of the Social Security Act Amendments of 1994, a supplier of medical equipment and supplies may distribute to physicians, or to individuals entitled to benefits under this part, a certificate of medical necessity for commercial purposes which contains no more than the following information completed by the supplier:

(I) An identification of the supplier and the beneficiary to whom such medical equipment and supplies are furnished.

(II) A description of such medical equipment and supplies.

(III) Any product code identifying such medical equipment and supplies.

(IV) Any other administrative information (other than information relating to the beneficiary's medical condition) identified by the Secretary.

(ii) INFORMATION ON PAYMENT AMOUNT AND CHARGES.—If a supplier distributes a certificate of medical necessity containing any of the information permitted to be supplied under clause (i), the supplier

shall also list on the certificate of medical necessity the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished prior to distribution of such certificate to the physician.

(iii) PENALTY.—Any supplier of medical equipment and supplies who knowingly and willfully distributes a certificate of medical necessity in violation of clause (i) or fails to provide the information required under clause (ii) is subject to a civil money penalty in an amount not to exceed $1,000 for each such certificate of medical necessity so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

(B) DEFINITION.—For purposes of this paragraph, the term "certificate of medical necessity" means a form or other document containing information required by the carrier to be submitted to show that an item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(3) COVERAGE AND REVIEW CRITERIA.—The Secretary shall annually review the coverage and utilization of items of medical equipment and supplies to determine whether such items should be made subject to coverage and utilization review criteria, and if appropriate, shall develop and apply such criteria to such items.

(4) LIMITATION ON PATIENT LIABILITY.—If a supplier of medical equipment and supplies (as defined in paragraph (5))—

(A) furnishes an item or service to a beneficiary for which no payment may be made by reason of paragraph (1);

(B) furnishes an item or service to a beneficiary for which payment is denied in advance under subsection (a)(15); or

(C) furnishes an item or service to a beneficiary for which payment is denied under section 1862(a)(1);

any expenses incurred for items and services furnished to an individual by such a supplier not on an assigned basis shall be the responsibility of such supplier. The individual shall have no financial responsibility for such expenses and the supplier shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected from the individual for such items or services. The provisions of subsection (a)(18) shall apply to refunds required under the previous sentence in the same manner as such provisions apply to refunds under such subsection.

(5) DEFINITION.—The term "medical equipment and supplies" means—

(A) durable medical equipment (as defined in section 1861(n));

(B) prosthetic devices (as described in section 1861(s)(8));

(C) orthotics and prosthetics (as described in section 1861(s)(9));

(D) surgical dressings (as described in section 1861(s)(5));

(E) such other items as the Secretary may determine; and

(F) for purposes of paragraphs (1) and (3)—

(i) home dialysis supplies and equipment (as described in section 1861(s)(2)(F)),

(ii) immunosuppressive drugs (as described in section 1861(s)(2)(J)),

(iii) therapeutic shoes for diabetics (as described in section 1861(s)(12)),

(iv) oral drugs prescribed for use as an anticancer therapeutic agent (as described in section 1861(s)(2)(Q)), and

(v) self-administered erythropoetin (as described in section 1861(s)(2)(P)).

(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—

(1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—

(A) for services furnished during 1998, the amount determined under paragraph (2); or

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

(A) the charges imposed for the services, or

(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection, the term "applicable fee schedule amount" means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848 for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term "adjusted reasonable costs" means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (relating to services provided by hospitals).

(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code

(or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(7) ADJUSTMENT IN DISCOUNT FOR CERTAIN MULTIPLE THERAPY SERVICES.—In the case of therapy services furnished on or after April 1, 2013, and for which payment is made under this subsection pursuant to the applicable fee schedule amount (as defined in paragraph (3)), 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 50 percent.

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner consistent with paragraph (11), except that such phase-in shall provide for full payment of any national mileage rate for ambulance services provided by suppliers that are paid by carriers in any of the 50 States where payment by a carrier for such services for all such suppliers in such State did not, prior to the implementation of the fee schedule, include a separate amount for all mileage within the county from which the beneficiary is transported.

(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month pe-

riod ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points;

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased, subject to subparagraph (C) and the succeeding sentence of this paragraph, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2002 by 1.0 percentage points; and

(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II).

The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the fee schedule under this subsection for a year being less than such payment rates for the preceding year.

(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(7) CODING SYSTEM.—The Secretary may require the claim for any services for which the amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(8) SERVICES FURNISHED BY CRITICAL ACCESS HOSPITALS.—Notwithstanding any other provision of this subsection, the Secretary shall pay 101 percent of the reasonable costs incurred in furnishing ambulance services if such services are furnished—

(A) by a critical access hospital (as defined in section 1861(mm)(1)), or

(B) by an entity that is owned and operated by a critical access hospital,

but only if the critical access hospital or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such critical access hospital.

(9) TRANSITIONAL ASSISTANCE FOR RURAL PROVIDERS.—In the case of ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which the transportation originates in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.

(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886(d)(2)) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the pay-

ment per mile otherwise applicable to miles in excess of 50 miles in such trip.

(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITY AREAS.—

(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2023, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

(B) IDENTIFICATION OF QUALIFIED RURAL AREAS.—

(i) DETERMINATION OF POPULATION DENSITY IN AREA.—Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

(ii) RANKING OF AREAS.—The Secretary shall rank each such area based on such population density.

(iii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as "qualified rural areas") with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

(iv) RURAL AREA.—For purposes of this paragraph, the term "rural area" has the meaning given such term in section 1886(d)(2)(D). If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.

(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2023, for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent (or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2023); and

(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent (or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2023).

(B) APPLICATION OF INCREASED PAYMENTS AFTER APPLICABLE PERIOD.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the applicable period specified in such subparagraph.

(14) PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.—

(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

(ii) complies with equipment and crew requirements established by the Secretary.

(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who certifies or reasonably determines that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

(C) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term "rural air ambulance service" means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual oc-

curs in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

(D) LIMITATION.—

(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1887) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

(15) PAYMENT ADJUSTMENT FOR NON-EMERGENCY AMBULANCE TRANSPORTS FOR ESRD BENEFICIARIES.—The fee schedule amount otherwise applicable under the preceding provisions of this subsection shall be reduced by 10 percent for ambulance services furnished during the period beginning on October 1, 2013, and ending on September 30, 2018, and by 23 percent for such services furnished on or after October 1, 2018, consisting of non-emergency basic life support services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1881(b)(14)(B)) furnished other than on an emergency basis by a provider of services or a renal dialysis facility.

(16) PRIOR AUTHORIZATION FOR REPETITIVE SCHEDULED NON-EMERGENT AMBULANCE TRANSPORTS.—

(A) IN GENERAL.—Beginning January 1, 2017, if the expansion to all States of the model of prior authorization described in paragraph (2) of section 515(a) of the Medicare Access and CHIP Reauthorization Act of 2015 meets the requirements described in paragraphs (1) through (3) of section 1115A(c), then the Secretary shall expand such model to all States.

(B) FUNDING.—The Secretary shall use funds made available under section 1893(h)(10) to carry out this paragraph.

(C) CLARIFICATION REGARDING BUDGET NEUTRALITY.—Nothing in this paragraph may be construed to limit or modify the application of section 1115A(b)(3)(B) to models described in such section, including with respect to the model described in subparagraph (A) and expanded beginning on January 1, 2017, under such subparagraph.

(17) SUBMISSION OF COST AND OTHER INFORMATION.—

(A) DEVELOPMENT OF DATA COLLECTION SYSTEM.—The Secretary shall develop a data collection system (which may include use of a cost survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers of services (in this paragraph referred to as "providers") and suppliers of ground ambulance services. Such system shall be designed to collect information—

(i) needed to evaluate the extent to which reported costs relate to payment rates under this subsection;

(ii) on the utilization of capital equipment and ambulance capacity, including information consistent with the type of information described in section 1121(a); and

(iii) on different types of ground ambulance services furnished in different geographic locations, including rural areas and low population density areas described in paragraph (12).

(B) SPECIFICATION OF DATA COLLECTION SYSTEM.—

(i) IN GENERAL.—The Secretary shall—

(I) not later than December 31, 2019, specify the data collection system under subparagraph (A); and

(II) identify the providers and suppliers of ground ambulance services that would be required to submit information under such data collection system, including the representative sample described in clause (ii).

(ii) DETERMINATION OF REPRESENTATIVE SAMPLE.—

(I) IN GENERAL.—Not later than December 31, 2019, with respect to the data collection for the first year under such system, and for each subsequent year through 2024, the Secretary shall determine a representative sample to submit information under the data collection system.

(II) REQUIREMENTS.—The sample under subclause (I) shall be representative of the different types of providers and suppliers of ground ambulance services (such as those providers and suppliers that are part of an emergency service or part of a government organization) and the geographic locations in which ground ambulance services are furnished (such as urban, rural, and low population density areas).

(III) LIMITATION.—The Secretary shall not include an individual provider or supplier of ground ambulance services in the sample under subclause (I) in 2 consecutive years, to the extent practicable.

(C) REPORTING OF COST INFORMATION.—For each year, a provider or supplier of ground ambulance services identified by the Secretary under subparagraph (B)(i)(II) as being required to submit information under the data collection system with respect to a period for the year shall

submit to the Secretary information specified under the system. Such information shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) PAYMENT REDUCTION FOR FAILURE TO REPORT.—

(i) IN GENERAL.—Beginning January 1, 2022, subject to clause (ii), a 10 percent reduction to payments under this subsection shall be made for the applicable period (as defined in clause (ii)) to a provider or supplier of ground ambulance services that—

(I) is required to submit information under the data collection system with respect to a period under subparagraph (C); and

(II) does not sufficiently submit such information, as determined by the Secretary.

(ii) APPLICABLE PERIOD DEFINED.—For purposes of clause (i), the term "applicable period" means, with respect to a provider or supplier of ground ambulance services, a year specified by the Secretary not more than 2 years after the end of the period with respect to which the Secretary has made a determination under clause (i)(II) that the provider or supplier of ground ambulance services failed to sufficiently submit information under the data collection system.

(iii) HARDSHIP EXEMPTION.—The Secretary may exempt a provider or supplier from the payment reduction under clause (i) with respect to an applicable period in the event of significant hardship, such as a natural disaster, bankruptcy, or other similar situation that the Secretary determines interfered with the ability of the provider or supplier of ground ambulance services to submit such information in a timely manner for the specified period.

(iv) INFORMAL REVIEW.—The Secretary shall establish a process under which a provider or supplier of ground ambulance services may seek an informal review of a determination that the provider or supplier is subject to the payment reduction under clause (i).

(E) ONGOING DATA COLLECTION.—

(i) REVISION OF DATA COLLECTION SYSTEM.—The Secretary may, as the Secretary determines appropriate and, if available, taking into consideration the report (or reports) under subparagraph (F), revise the data collection system under subparagraph (A).

(ii) SUBSEQUENT DATA COLLECTION.—In order to continue to evaluate the extent to which reported costs relate to payment rates under this subsection and for other purposes the Secretary deems appropriate, the Secretary shall require providers and suppliers of ground ambulance services to submit information for years after 2024 as the Secretary determines appropriate, but in no case less often than once every 3 years.

(F) GROUND AMBULANCE DATA COLLECTION SYSTEM STUDY.—

(i) IN GENERAL.—Not later than March 15, 2023, and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

(ii) CONTENTS.—A report under clause (i) shall contain the following:

(I) An analysis of information submitted through the data collection system.

(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.

(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such system should be revised under subparagraph (E)(i).

(IV) Other information determined appropriate by the Commission.

(G) PUBLIC AVAILABILITY.—The Secretary shall post information on the results of the data collection under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services, as determined appropriate by the Secretary.

(H) IMPLEMENTATION.—The Secretary shall implement this paragraph through notice and comment rulemaking.

(I) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information required under this subsection.

(J) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the data collection system or identification of respondents under this paragraph.

(K) FUNDING FOR IMPLEMENTATION.—For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2018. Amounts transferred under this subparagraph shall remain available until expended.

(m) PAYMENT FOR TELEHEALTH SERVICES.—

(1) IN GENERAL.—The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. For purposes of the preceding sentence, in the case of any Federal telemedicine demonstration program conducted in Alaska or Hawaii,

the term "telecommunications system" includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

(2) PAYMENT AMOUNT.—

(A) DISTANT SITE.—The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.

(B) FACILITY FEE FOR ORIGINATING SITE.—

(i) IN GENERAL.—Subject to clause (ii) and paragraph (6)(C), with respect to a telehealth service, subject to section 1833(a)(1)(U), there shall be paid to the originating site a facility fee equal to—

(I) for the period beginning on October 1, 2001, and ending on December 31, 2001, and for 2002, $20; and

(II) for a subsequent year, the facility fee specified in subclause (I) or this subclause for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

(ii) NO FACILITY FEE IF ORIGINATING SITE IS THE HOME.—No facility fee shall be paid under this subparagraph to an originating site described in paragraph (4)(C)(ii)(X).

(C) TELEPRESENTER NOT REQUIRED.—Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site).

(3) LIMITATION ON BENEFICIARY CHARGES.—

(A) PHYSICIAN AND PRACTITIONER.—The provisions of section 1848(g) and subparagraphs (A) and (B) of section 1842(b)(18) shall apply to a physician or practitioner receiving payment under this subsection in the same manner as they apply to physicians or practitioners under such sections.

(B) ORIGINATING SITE.—The provisions of section 1842(b)(18) shall apply to originating sites receiving a facility fee in the same manner as they apply to practitioners under such section.

(4) DEFINITIONS.—For purposes of this subsection:

(A) DISTANT SITE.—The term "distant site" means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

(B) ELIGIBLE TELEHEALTH INDIVIDUAL.—The term "eligible telehealth individual" means an individual enrolled

under this part who receives a telehealth service furnished at an originating site.

(C) ORIGINATING SITE.—

(i) IN GENERAL.—Except as provided in paragraphs (5), (6), and (7), the term"originating site" means only those sites described in clause (ii) at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system and only if such site is located—

(I) in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));

(II) in a county that is not included in a Metropolitan Statistical Area; or

(III) from an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

(ii) SITES DESCRIBED.—The sites referred to in clause (i) are the following sites:

(I) The office of a physician or practitioner.

(II) A critical access hospital (as defined in section 1861(mm)(1)).

(III) A rural health clinic (as defined in section 1861(aa)(2)).

(IV) A Federally qualified health center (as defined in section 1861(aa)(4)).

(V) A hospital (as defined in section 1861(e)).

(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).

(VII) A skilled nursing facility (as defined in section 1819(a)).

(VIII) A community mental health center (as defined in section 1861(ff)(3)(B)).

(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).

(X) The home of an individual, but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7).

(D) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r).

(E) PRACTITIONER.—The term "practitioner" has the meaning given that term in section 1842(b)(18)(C).

(F) TELEHEALTH SERVICE.—

(i) IN GENERAL.—The term "telehealth service" means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

(ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addi-

tion or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1).

(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1881(b)(3)(B), at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii).

(6) TREATMENT OF STROKE TELEHEALTH SERVICES.—

(A) NON-APPLICATION OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, as determined by the Secretary.

(B) INCLUSION OF CERTAIN SITES.—With respect to telehealth services described in subparagraph (A), the term "originating site" shall include any hospital (as defined in section 1861(e)) or critical access hospital (as defined in section 1861(mm)(1)), any mobile stroke unit (as defined by the Secretary), or any other site determined appropriate by the Secretary, at which the eligible telehealth individual is located at the time the service is furnished via a telecommunications system.

(C) NO ORIGINATING SITE FACILITY FEE FOR NEW SITES.—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).

(7) TREATMENT OF SUBSTANCE USE DISORDER SERVICES FURNISHED THROUGH TELEHEALTH.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after July 1, 2019, to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder, as determined by the Secretary, at an originating site described in paragraph (4)(C)(ii) (other than an originating site described in subclause (IX) of such paragraph).

(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

(1) modify—

(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such

section that has not received a grade of A, B, C, or I by such Task Force.

(o) DEVELOPMENT AND IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) DEVELOPMENT.—

(A) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health center services furnished by Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers and shall establish payment rates for specific payment codes based on such appropriate descriptions of services. Such system shall be established to take into account the type, intensity, and duration of services furnished by Federally qualified health centers. Such system may include adjustments, including geographic adjustments, determined appropriate by the Secretary.

(B) COLLECTION OF DATA AND EVALUATION.—By not later than January 1, 2011, the Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this subsection, including the reporting of services using HCPCS codes.

(2) IMPLEMENTATION.—

(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(A), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments of prospective payment rates for Federally qualified health center services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(B) PAYMENTS.—

(i) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated aggregate amount of prospective payment rates (determined prior to the application of section 1833(a)(1)(Z)) under this title for Federally qualified health center services in the first year that such system is implemented is equal to 100 percent of the estimated amount of reasonable costs (determined without the application of a per visit payment limit or productivity screen and prior to the application of section 1866(a)(2)(A)(ii)) that would have occurred for such services under this title in such year if the system had not been implemented.

(ii) PAYMENTS IN SUBSEQUENT YEARS.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

(I) in the first year after implementation of such system, by the percentage increase in the MEI (as

defined in section 1842(i)(3)) for the year involved; and

(II) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

(C) PREPARATION FOR PPS IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may establish and implement by program instruction or otherwise the payment codes to be used under the prospective payment system under this section.

(3) ADDITIONAL PAYMENTS FOR CERTAIN FQHCS WITH PHYSICIANS OR OTHER PRACTITIONERS RECEIVING DATA 2000 WAIVERS.—

(A) IN GENERAL.—In the case of a Federally qualified health center with respect to which, beginning on or after January 1, 2019, Federally qualified health center services (as defined in section 1861(aa)(3)) are furnished for the treatment of opioid use disorder by a physician or practitioner who meets the requirements described in subparagraph (C), the Secretary shall, subject to availability of funds under subparagraph (D), make a payment (at such time and in such manner as specified by the Secretary) to such Federally qualified health center after receiving and approving an application submitted by such Federally qualified health center under subparagraph (B). Such a payment shall be in an amount determined by the Secretary, based on an estimate of the average costs of training for purposes of receiving a waiver described in subparagraph (C)(ii). Such a payment may be made only one time with respect to each such physician or practitioner.

(B) APPLICATION.—In order to receive a payment described in subparagraph (A), a Federally qualified health center shall submit to the Secretary an application for such a payment at such time, in such manner, and containing such information as specified by the Secretary. A Federally qualified health center may apply for such a payment for each physician or practitioner described in subparagraph (A) furnishing services described in such subparagraph at such center.

(C) REQUIREMENTS.—For purposes of subparagraph (A), the requirements described in this subparagraph, with respect to a physician or practitioner, are the following:

(i) The physician or practitioner is employed by or working under contract with a Federally qualified health center described in subparagraph (A) that submits an application under subparagraph (B).

(ii) The physician or practitioner first receives a waiver under section 303(g) of the Controlled Substances Act on or after January 1, 2019.

(D) FUNDING.—For purposes of making payments under this paragraph, there are appropriated, out of amounts in

the Treasury not otherwise appropriated, $6,000,000, which shall remain available until expended.

(p) QUALITY INCENTIVES TO PROMOTE PATIENT SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOGRAPHY.—

(1) QUALITY INCENTIVES.—In the case of an applicable computed tomography service (as defined in paragraph (2)) for which payment is made under an applicable payment system (as defined in paragraph (3)) and that is furnished on or after January 1, 2016, using equipment that is not consistent with the CT equipment standard (described in paragraph (4)), the payment amount for such service shall be reduced by the applicable percentage (as defined in paragraph (5)).

(2) APPLICABLE COMPUTED TOMOGRAPHY SERVICES DEFINED.—In this subsection, the term "applicable computed tomography service" means a service billed using diagnostic radiological imaging codes for computed tomography (identified as of January 1, 2014, by HCPCS codes 70450–70498, 71250–71275, 72125–72133, 72191–72194, 73200–73206, 73700–73706, 74150–74178, 74261–74263, and 75571–75574 (and any succeeding codes).

(3) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term "applicable payment system" means the following:

(A) The technical component and the technical component of the global fee under the fee schedule established under section 1848(b).

(B) The prospective payment system for hospital outpatient department services under section 1833(t).

(4) CONSISTENCY WITH CT EQUIPMENT STANDARD.—In this subsection, the term "not consistent with the CT equipment standard" means, with respect to an applicable computed tomography service, that the service was furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR–29–2013, entitled "Standard Attributes on CT Equipment Related to Dose Optimization and Management". Through rulemaking, the Secretary may apply successor standards.

(5) APPLICABLE PERCENTAGE DEFINED.—In this subsection, the term "applicable percentage" means—

(A) for 2016, 5 percent; and

(B) for 2017 and subsequent years, 15 percent.

(6) IMPLEMENTATION.—

(A) INFORMATION.—The Secretary shall require that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable computed tomography service was furnished that was not consistent with the CT equipment standard (described in paragraph (4)). Such information may be included on a claim and may be a modifier. Such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under section 1834(e) and hospitals under section 1865(a).

(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information described in subparagraph (A).

(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) PROGRAM ESTABLISHED.—

(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term "appropriate use criteria" means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria shall be evidence-based.

(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term "applicable imaging service" means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

(iii) one or more of such mechanisms is available free of charge.

(D) APPLICABLE SETTING DEFINED.—In this subsection, the term "applicable setting" means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term "ordering professional" means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service.

(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term "furnishing professional" means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service.

(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities.

(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

(i) have stakeholder consensus;

(ii) are scientifically valid and evidence based; and

(iii) are based on studies that are published and reviewable by stakeholders.

(C) REVISIONS.—The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rulemaking.

(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criterion applies with respect to an applicable imaging service, the Secretary shall apply one or more applicable appropriate use criteria under this paragraph for the service.

(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(i) IN GENERAL.—The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

(III) Use of a clinical decision support mechanism established by the Secretary.

(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

(ii) REQUIREMENTS.—The requirements described in this clause are the following:

(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

(II) In the case where there is more than one applicable appropriate use criterion specified under such paragraph for an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

(VI) The mechanism meets privacy and security standards under applicable provisions of law.

(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

(ii) PERIODIC UPDATING OF LIST.—The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable pay-

ment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

(ii) Information regarding—

(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

(II) whether the service ordered would not adhere to such criteria; or

(III) whether such criteria was not applicable to the service ordered.

(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

(iii) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term "applicable payment system" means the following:

(i) The physician fee schedule established under section 1848(b).

(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

(iii) The ambulatory surgical center payment systems under section 1833(i).

(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2),

which may be based on comparison to other ordering professionals; and

(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

(B) APPROPRIATE USE CRITERIA IN PRIOR AUTHORIZATION.—In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

(C) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

(7) CONSTRUCTION.—Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

(r) PAYMENT FOR RENAL DIALYSIS SERVICES FOR INDIVIDUALS WITH ACUTE KIDNEY INJURY.—

(1) PAYMENT RATE.—In the case of renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) furnished under this part by a renal dialysis facility or provider of services paid under such section during a year (beginning with 2017) to an individual with acute kidney injury (as defined in paragraph (2)), the amount of payment under this part for such services shall be the base rate for renal dialysis services determined for such year under such section, as adjusted by any applicable geographic adjustment factor applied under subparagraph (D)(iv)(II) of such section and may be adjusted by the Secretary (on a budget neutral basis for payments under this paragraph) by any other adjustment factor under subparagraph (D) of such section.

(2) INDIVIDUAL WITH ACUTE KIDNEY INJURY DEFINED.—In this subsection, the term "individual with acute kidney injury"

means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1881(b)(14).

(s) PAYMENT FOR APPLICABLE DISPOSABLE DEVICES.—

(1) SEPARATE PAYMENT.—The Secretary shall make a payment (separate from the payments otherwise made under section 1895) in the amount established under paragraph (3) to a home health agency for an applicable disposable device (as defined in paragraph (2)) when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under section 1895(b).

(2) APPLICABLE DISPOSABLE DEVICE.—In this subsection, the term applicable disposable device means a disposable device that, as determined by the Secretary, is—

(A) a disposable negative pressure wound therapy device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy; and

(B) a substitute for, and used in lieu of, a negative pressure wound therapy durable medical equipment item that is an integrated system of a negative pressure vacuum pump, a separate exudate collection canister, and dressings that would otherwise be covered for individuals for such wound therapy.

(3) PAYMENT AMOUNT.—The separate payment amount established under this paragraph for an applicable disposable device for a year shall be equal to the amount of the payment that would be made under section 1833(t) (relating to payment for covered OPD services) for the year for the Level I Healthcare Common Procedure Coding System (HCPCS) code for which the description for a professional service includes the furnishing of such device.

(t) SITE-OF-SERVICE PRICE TRANSPARENCY.—

(1) IN GENERAL.—In order to facilitate price transparency with respect to items and services for which payment may be made either to a hospital outpatient department or to an ambulatory surgical center under this title, the Secretary shall, for 2018 and each year thereafter, make available to the public via a searchable Internet website, with respect to an appropriate number of such items and services—

(A) the estimated payment amount for the item or service under the outpatient department fee schedule under subsection (t) of section 1833 and the ambulatory surgical center payment system under subsection (i) of such section; and

(B) the estimated amount of beneficiary liability applicable to the item or service.

(2) CALCULATION OF ESTIMATED BENEFICIARY LIABILITY.—For purposes of paragraph (1)(B), the estimated amount of beneficiary liability, with respect to an item or service, is the amount for such item or service for which an individual who does not have coverage under a Medicare supplemental policy certified under section 1882 or any other supplemental insurance coverage is responsible.

(3) IMPLEMENTATION.—In carrying out this subsection, the Secretary—

(A) shall include in the notice described in section 1804(a) a notification of the availability of the estimated amounts made available under paragraph (1); and

(B) may utilize mechanisms in existence on the date of enactment of this subsection, such as the portion of the Internet website of the Centers for Medicare & Medicaid Services on which information comparing physician performance is posted (commonly referred to as the Physician Compare Internet website), to make available such estimated amounts under such paragraph.

(4) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account, of $6,000,000 for fiscal year 2017, to remain available until expended.

(u) PAYMENT AND RELATED REQUIREMENTS FOR HOME INFUSION THERAPY.—

(1) PAYMENT.—

(A) SINGLE PAYMENT.—

(i) IN GENERAL.—Subject to clause (iii) and subparagraphs (B) and (C), the Secretary shall implement a payment system under which a single payment is made under this title to a qualified home infusion therapy supplier for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2)) furnished by a qualified home infusion therapy supplier (as defined in section 1861(iii)(3)(D)) in coordination with the furnishing of home infusion drugs (as defined in section 1861(iii)(3)(C)) under this part.

(ii) UNIT OF SINGLE PAYMENT.—A unit of single payment under the payment system implemented under this subparagraph is for each infusion drug administration calendar day in the individual's home. The Secretary shall, as appropriate, establish single payment amounts for types of infusion therapy, including to take into account variation in utilization of nursing services by therapy type.

(iii) LIMITATION.—The single payment amount determined under this subparagraph after application of subparagraph (B) and paragraph (3) shall not exceed the amount determined under the fee schedule under section 1848 for infusion therapy services furnished in a calendar day if furnished in a physician office setting, except such single payment shall not reflect more than 5 hours of infusion for a particular therapy in a calendar day.

(B) REQUIRED ADJUSTMENTS.—The Secretary shall adjust the single payment amount determined under subparagraph (A) for home infusion therapy services under section 1861(iii)(1) to reflect other factors such as—

(i) a geographic wage index and other costs that may vary by region; and

(ii) patient acuity and complexity of drug administration.

(C) DISCRETIONARY ADJUSTMENTS.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may adjust the single payment amount determined under subparagraph (A) (after application of subparagraph (B)) to reflect outlier situations and other factors as the Secretary determines appropriate.

(ii) REQUIREMENT OF BUDGET NEUTRALITY.—Any adjustment under this subparagraph shall be made in a budget neutral manner.

(2) CONSIDERATIONS.—In developing the payment system under this subsection, the Secretary may consider the costs of furnishing infusion therapy in the home, consult with home infusion therapy suppliers, consider payment amounts for similar items and services under this part and part A, and consider payment amounts established by Medicare Advantage plans under part C and in the private insurance market for home infusion therapy (including average per treatment day payment amounts by type of home infusion therapy).

(3) ANNUAL UPDATES.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall update the single payment amount under this subsection from year to year beginning in 2022 by increasing the single payment amount from the prior year by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year.

(B) ADJUSTMENT.—For each year, the Secretary shall reduce the percentage increase described in subparagraph (A) by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in a percentage being less than 0.0 for a year, and may result in payment being less than such payment rates for the preceding year.

(4) AUTHORITY TO APPLY PRIOR AUTHORIZATION.—The Secretary may, as determined appropriate by the Secretary, apply prior authorization for home infusion therapy services under section 1861(iii)(1).

(5) ACCREDITATION OF QUALIFIED HOME INFUSION THERAPY SUPPLIERS.—

(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

(i) The ability of the organization to conduct timely reviews of accreditation applications.

(ii) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

(iii) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

(iv) Such other factors as the Secretary determines appropriate.

(B) DESIGNATION.—Not later than January 1, 2021, the Secretary shall designate organizations to accredit suppliers furnishing home infusion therapy. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation organizations designated under subparagraph (B).

(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

(D) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2021, by an accreditation organization designated by the Secretary under subparagraph (B) as of January 1, 2019, such supplier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2023, for the remaining period such accreditation is in effect.

(6) NOTIFICATION OF INFUSION THERAPY OPTIONS AVAILABLE PRIOR TO FURNISHING HOME INFUSION THERAPY.—Prior to the furnishing of home infusion therapy to an individual, the physician who establishes the plan described in section 1861(iii)(1) for the individual shall provide notification (in a form, manner, and frequency determined appropriate by the Secretary) of the options available (such as home, physician's office, hospital outpatient department) for the furnishing of infusion therapy under this part.

(7) HOME INFUSION THERAPY SERVICES TEMPORARY TRANSITIONAL PAYMENT.—

(A) TEMPORARY TRANSITIONAL PAYMENT.—

(i) IN GENERAL.—The Secretary shall, in accordance with the payment methodology described in subparagraph (B) and subject to the provisions of this paragraph, provide a home infusion therapy services temporary transitional payment under this part to an eli-

gible home infusion supplier (as defined in subparagraph (F)) for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2)) furnished during the period specified in clause (ii) by such supplier in coordination with the furnishing of transitional home infusion drugs (as defined in clause (iii)).

(ii) PERIOD SPECIFIED.—For purposes of clause (i), the period specified in this clause is the period beginning on January 1, 2019, and ending on the day before the date of the implementation of the payment system under paragraph (1)(A).

(iii) TRANSITIONAL HOME INFUSION DRUG DEFINED.—For purposes of this paragraph, the term "transitional home infusion drug" has the meaning given to the term "home infusion drug" under section 1861(iii)(3)(C)), except that clause (ii) of such section shall not apply if a drug described in such clause is identified in clauses (i), (ii), (iii) or (iv) of subparagraph (C) as of the date of the enactment of this paragraph.

(B) PAYMENT METHODOLOGY.—For purposes of this paragraph, the Secretary shall establish a payment methodology, with respect to items and services described in subparagraph (A)(i). Under such payment methodology the Secretary shall—

(i) create the three payment categories described in clauses (i), (ii), and (iii) of subparagraph (C);

(ii) assign drugs to such categories, in accordance with such clauses;

(iii) assign appropriate Healthcare Common Procedure Coding System (HCPCS) codes to each payment category; and

(iv) establish a single payment amount for each such payment category, in accordance with subparagraph (D), for each infusion drug administration calendar day in the individual's home for drugs assigned to such category.

(C) PAYMENT CATEGORIES.—

(i) PAYMENT CATEGORY 1.—The Secretary shall create a payment category 1 and assign to such category drugs which are covered under the Local Coverage Determination on External Infusion Pumps (LCD number L33794) and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1570, J2175, J2260, J2270, J2274, J2278, J3010, or J3285.

(ii) PAYMENT CATEGORY 2.—The Secretary shall create a payment category 2 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J1555 JB, J1559 JB, J1561 JB, J1562 JB, J1569 JB, or J1575 JB.

(iii) PAYMENT CATEGORY 3.—The Secretary shall create a payment category 3 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of January 1, 2018, and as subsequently modified by the Secretary): J9000, J9039, J9040, J9065, J9100, J9190, J9200, J9360, or J9370.

(iv) INFUSION DRUGS NOT OTHERWISE INCLUDED.—With respect to drugs that are not included in payment category 1, 2, or 3 under clause (i), (ii), or (iii), respectively, the Secretary shall assign to the most appropriate of such categories, as determined by the Secretary, drugs which are—

(I) covered under such local coverage determination and billed under HCPCS codes J7799 or J7999 (as identified as of July 1, 2017, and as subsequently modified by the Secretary); or

(II) billed under any code that is implemented after the date of the enactment of this paragraph and included in such local coverage determination or included in subregulatory guidance as a home infusion drug described in subparagraph (A)(i).

(D) PAYMENT AMOUNTS.—

(i) IN GENERAL.—Under the payment methodology, the Secretary shall pay eligible home infusion suppliers, with respect to items and services described in subparagraph (A)(i) furnished during the period described in subparagraph (A)(ii) by such supplier to an individual, at amounts equal to the amounts determined under the physician fee schedule established under section 1848 for services furnished during the year for codes and units of such codes described in clauses (ii), (iii), and (iv) with respect to drugs included in the payment category under subparagraph (C) specified in the respective clause, determined without application of the geographic adjustment under subsection (e) of such section.

(ii) PAYMENT AMOUNT FOR CATEGORY 1.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 1 described in subparagraph (C)(i), are one unit of HCPCS code 96365 plus three units of HCPCS code 96366 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iii) PAYMENT AMOUNT FOR CATEGORY 2.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 2 described in subparagraph (C)(i), are one unit of HCPCS code 96369 plus three units of HCPCS code 96370 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(iv) PAYMENT AMOUNT FOR CATEGORY 3.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 3 described in subparagraph (C)(i), are one

unit of HCPCS code 96413 plus three units of HCPCS code 96415 (as identified as of January 1, 2018, and as subsequently modified by the Secretary).

(E) CLARIFICATIONS.—

(i) INFUSION DRUG ADMINISTRATION DAY.—For purposes of this subsection, with respect to the furnishing of transitional home infusion drugs or home infusion drugs to an individual by an eligible home infusion supplier or a qualified home infusion therapy supplier, a reference to payment to such supplier for an infusion drug administration calendar day in the individual's home shall refer to payment only for the date on which professional services (as described in section 1861(iii)(2)(A)) were furnished to administer such drugs to such individual. For purposes of the previous sentence, an infusion drug administration calendar day shall include all such drugs administered to such individual on such day.

(ii) TREATMENT OF MULTIPLE DRUGS ADMINISTERED ON SAME INFUSION DRUG ADMINISTRATION DAY.—In the case that an eligible home infusion supplier, with respect to an infusion drug administration calendar day in an individual's home, furnishes to such individual transitional home infusion drugs which are not all assigned to the same payment category under subparagraph (C), payment to such supplier for such infusion drug administration calendar day in the individual's home shall be a single payment equal to the amount of payment under this paragraph for the drug, among all such drugs so furnished to such individual during such calendar day, for which the highest payment would be made under this paragraph.

(F) ELIGIBLE HOME INFUSION SUPPLIERS.—In this paragraph, the term "eligible home infusion supplier" means a supplier that is enrolled under this part as a pharmacy that provides external infusion pumps and external infusion pump supplies and that maintains all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered.

(G) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(v) PAYMENT FOR OUTPATIENT PHYSICAL THERAPY SERVICES AND OUTPATIENT OCCUPATIONAL THERAPY SERVICES FURNISHED BY A THERAPY ASSISTANT.—

(1) IN GENERAL.—In the case of an outpatient physical therapy service or outpatient occupational therapy service furnished on or after January 1, 2022, for which payment is made under section 1848 or subsection (k), that is furnished in whole or in part by a therapy assistant (as defined by the Secretary), the amount of payment for such service shall be an amount equal to 85 percent of the amount of payment otherwise applicable for the service under this part. Nothing in the preceding sentence shall be construed to change applicable requirements with respect to such services.

(2) USE OF MODIFIER.—

(A) ESTABLISHMENT.—Not later than January 1, 2019, the Secretary shall establish a modifier to indicate (in a form and manner specified by the Secretary), in the case of an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined), that the service was furnished by a therapy assistant.

(B) REQUIRED USE.—Each request for payment, or bill submitted, for an outpatient physical therapy service or outpatient occupational therapy service furnished in whole or in part by a therapy assistant (as so defined) on or after January 1, 2020, shall include the modifier established under subparagraph (A) for each such service.

(3) IMPLEMENTATION.—The Secretary shall implement this subsection through notice and comment rulemaking.

(w) OPIOID USE DISORDER TREATMENT SERVICES.—

(1) IN GENERAL.—The Secretary shall pay to an opioid treatment program (as defined in paragraph (2) of section 1861(jjj)) an amount that is equal to 100 percent of a bundled payment under this part for opioid use disorder treatment services (as defined in paragraph (1) of such section) that are furnished by such program to an individual during an episode of care (as defined by the Secretary) beginning on or after January 1, 2020. The Secretary shall ensure, as determined appropriate by the Secretary, that no duplicative payments are made under this part or part D for items and services furnished by an opioid treatment program.

(2) CONSIDERATIONS.—The Secretary may implement this subsection through one or more bundles based on the type of medication provided (such as buprenorphine, methadone, naltrexone, or a new innovative drug), the frequency of services, the scope of services furnished, characteristics of the individuals furnished such services, or other factors as the Secretary determine appropriate. In developing such bundles, the Secretary may consider payment rates paid to opioid treatment programs for comparable services under State plans under title XIX or under the TRICARE program under chapter 55 of title 10 of the United States Code.

(3) ANNUAL UPDATES.—The Secretary shall provide an update each year to the bundled payment amounts under this subsection.

(x) LIMITATION FOR VISION SERVICES.—With respect to vision services (as defined in section 1861(kkk)) and an individual, payment may be made under this part for only 1 routine eye examination described in paragraph (1) of such section and 1 contact lens fitting service described in paragraph (2) of such section during a 2-year period.

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COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

(1) IMPLEMENTATION OF PROGRAMS.—

(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

(B) PHASED-IN IMPLEMENTATION.—The programs—

(i) shall be phased in among competitive acquisition areas in a manner consistent with subparagraph (D) so that the competition under the programs occurs in—

(I) 10 of the largest metropolitan statistical areas in 2007;

(II) an additional 91 of the largest metropolitan statistical areas in 2011; and

(III) additional areas after 2011 (or, in the case of national mail order for items and services, after 2010); and

(ii) may be phased in first among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential.

(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

(D) CHANGES IN COMPETITIVE ACQUISITION PROGRAMS.—

(i) ROUND 1 OF COMPETITIVE ACQUISITION PROGRAM.—Notwithstanding subparagraph (B)(i)(I) and in implementing the first round of the competitive acquisition programs under this section—

(I) the contracts awarded under this section before the date of the enactment of this subparagraph are terminated, no payment shall be made under this title on or after the date of the enactment of this subparagraph based on such a contract, and, to the extent that any damages may be applicable as a result of the termination of such contracts, such damages shall be payable from the Federal Supplementary Medical Insurance Trust Fund under section 1841;

(II) the Secretary shall conduct the competition for such round in a manner so that it occurs in 2009 with respect to the same items and services and the same areas, except as provided in subclauses (III) and (IV);

(III) the Secretary shall exclude Puerto Rico so that such round of competition covers 9, instead of 10, of the largest metropolitan statistical areas; and

(IV) there shall be excluded negative pressure wound therapy items and services.

Nothing in subclause (I) shall be construed to provide an independent cause of action or right to administrative or

judicial review with regard to the termination provided under such subclause.

(ii) ROUND 2 OF COMPETITIVE ACQUISITION PROGRAM.—In implementing the second round of the competitive acquisition programs under this section described in subparagraph (B)(i)(II)—

(I) the metropolitan statistical areas to be included shall be those metropolitan statistical areas selected by the Secretary for such round as of June 1, 2008;

(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and

(III) the Secretary may subdivide metropolitan statistical areas with populations (based upon the most recent data from the Census Bureau) of at least 8,000,000 into separate areas for competitive acquisition purposes.

(iii) EXCLUSION OF CERTAIN AREAS IN SUBSEQUENT ROUNDS OF COMPETITIVE ACQUISITION PROGRAMS.—In implementing subsequent rounds of the competitive acquisition programs under this section, including under subparagraph (B)(i)(III), for competitions occurring before 2015, the Secretary shall exempt from the competitive acquisition program (other than national mail order) the following:

(I) Rural areas.

(II) Metropolitan statistical areas not selected under round 1 or round 2 with a population of less than 250,000.

(III) Areas with a low population density within a metropolitan statistical area that is otherwise selected, as determined for purposes of paragraph (3)(A).

(E) VERIFICATION BY OIG.—The Inspector General of the Department of Health and Human Services shall, through post-award audit, survey, or otherwise, assess the process used by the Centers for Medicare & Medicaid Services to conduct competitive bidding and subsequent pricing determinations under this section that are the basis for pivotal bid amounts and single payment amounts for items and services in competitive bidding areas under rounds 1 and 2 of the competitive acquisition programs under this section and may continue to verify such calculations for subsequent rounds of such programs.

(F) SUPPLIER FEEDBACK ON MISSING FINANCIAL DOCUMENTATION.—

(i) IN GENERAL.—In the case of a bid where one or more covered documents in connection with such bid have been submitted not later than the covered document review date specified in clause (ii), the Secretary—

(I) shall provide, by not later than 45 days (in the case of the first round of the competitive acquisition programs as described in subparagraph (B)(i)(I)) or 90 days (in the case of a subsequent round of such programs) after the covered document review date, for notice to the bidder of

all such documents that are missing as of the covered document review date; and

(II) may not reject the bid on the basis that any covered document is missing or has not been submitted on a timely basis, if all such missing documents identified in the notice provided to the bidder under subclause (I) are submitted to the Secretary not later than 10 business days after the date of such notice.

(ii) COVERED DOCUMENT REVIEW DATE.—The covered document review date specified in this clause with respect to a competitive acquisition program is the later of—

(I) the date that is 30 days before the final date specified by the Secretary for submission of bids under such program; or

(II) the date that is 30 days after the first date specified by the Secretary for submission of bids under such program.

(iii) LIMITATIONS OF PROCESS.—The process provided under this subparagraph—

(I) applies only to the timely submission of covered documents;

(II) does not apply to any determination as to the accuracy or completeness of covered documents submitted or whether such documents meet applicable requirements;

(III) shall not prevent the Secretary from rejecting a bid based on any basis not described in clause (i)(II); and

(IV) shall not be construed as permitting a bidder to change bidding amounts or to make other changes in a bid submission.

(iv) COVERED DOCUMENT DEFINED.—In this subparagraph, the term "covered document" means a financial, tax, or other document required to be submitted by a bidder as part of an original bid submission under a competitive acquisition program in order to meet required financial standards. Such term does not include other documents, such as the bid itself or accreditation documentation.

(G) REQUIRING BID BONDS FOR BIDDING ENTITIES.—With respect to rounds of competitions beginning under this subsection for contracts beginning not earlier than January 1, 2017, and not later than January 1, 2019, an entity may not submit a bid for a competitive acquisition area unless, as of the deadline for bid submission, the entity has obtained (and provided the Secretary with proof of having obtained) a bid surety bond (in this paragraph referred to as a "bid bond") in a form specified by the Secretary consistent with subparagraph (H) and in an amount that is not less than $50,000 and not more than $100,000 for each competitive acquisition area in which the entity submits the bid.

(H) TREATMENT OF BID BONDS SUBMITTED.—

(i) FOR BIDDERS THAT SUBMIT BIDS AT OR BELOW THE MEDIAN AND ARE OFFERED BUT DO NOT ACCEPT THE CONTRACT.—In the case of a bidding entity that is offered a contract for any product category for a competitive acquisition area, if—

(I) the entity's composite bid for such product category and area was at or below the median composite bid rate for all bidding entities included in the calculation of the single payment amounts for such product category and area; and

(II) the entity does not accept the contract offered for such product category and area,

the bid bond submitted by such entity for such area shall be forfeited by the entity and the Secretary shall collect on it.

(ii) TREATMENT OF OTHER BIDDERS.—In the case of a bidding entity for any product category for a competitive acquisition area, if the entity does not meet the bid forfeiture conditions in subclauses (I) and (II) of clause (i) for any product category for such area, the bid bond submitted by such entity for such area shall be returned within 90 days of the public announcement of the contract suppliers for such area.

(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

(A) DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.—Covered items (as defined in section 1834(a)(13)) for which payment would otherwise be made under section 1834(a), including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act, excluding certain complex rehabilitative power wheelchairs recognized by the Secretary as classified within group 3 or higher (and related accessories when furnished in connection with such wheelchairs), and excluding drugs and biologicals describedin section 1842(o)(1)(D).

(B) OTHER EQUIPMENT AND SUPPLIES.—Items and services described in section 1842(s)(2)(D), other than parenteral nutrients, equipment, and supplies.

(C) OFF-THE-SHELF ORTHOTICS.—Orthotics described in section 1861(s)(9) for which payment would otherwise be made under section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

(D) EYEGLASSES AND CONTACT LENSES.—Eyeglasses and contact lenses for which payment would otherwise be made under section 1834(h).

(3) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT AND OXYGEN.—In the case of a covered

item for which payment is made on a rental basis under section 1834(a) and in the case of payment for oxygen under section 1834(a)(5), the Secretary shall establish a process by which rental agreements for the covered items and supply arrangements with oxygen suppliers entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1834(a).

(5) PHYSICIAN AUTHORIZATION.—

(A) IN GENERAL.—With respect to items or services included within a particular HCPCS code, the Secretary may establish a process for certain items and services under which a physician may prescribe a particular brand or mode of delivery of an item or service within such code if the physician determines that use of the particular item or service would avoid an adverse medical outcome on the individual, as determined by the Secretary.

(B) NO EFFECT ON PAYMENT AMOUNT.—A prescription under subparagraph (A) shall not affect the amount of payment otherwise applicable for the item or service under the code involved.

(6) APPLICATION.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a), section 1834(h), or section 1842(s), as appropriate.

(7) EXEMPTION FROM COMPETITIVE ACQUISITION.—The programs under this section shall not apply to the following:

(A) CERTAIN OFF-THE-SHELF ORTHOTICS.—Items and services described in paragraph (2)(C) if furnished—

(i) by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service; or

(ii) by a hospital to the hospital's own patients during an admission or on the date of discharge.

(B) CERTAIN DURABLE MEDICAL EQUIPMENT.—Those items and services described in paragraph (2)(A)—

(i) that are furnished by a hospital to the hospital's own patients during an admission or on the date of discharge; and

(ii) to which such programs would not apply, as specified by the Secretary, if furnished by a physician to the physician's own patients as part of the physician's professional service.

(C) CERTAIN EYEGLASSES AND CONTACT LENSES.—Those items and services described in paragraph (2)(D) if furnished by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service.

(b) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

(2) CONDITIONS FOR AWARDING CONTRACT.—

(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

(i) The entity meets applicable quality standards specified by the Secretary under section 1834(a)(20).

(ii) The entity meets applicable financial standards specified by the Secretary, taking into account the needs of small providers.

(iii) The total amounts to be paid to contractors in a competitive acquisition area are expected to be less than the total amounts that would otherwise be paid.

(iv) Access of individuals to a choice of multiple suppliers in the area is maintained.

(v) The entity meets applicable State licensure requirements.

(B) TIMELY IMPLEMENTATION OF PROGRAM.—Any delay in the implementation of quality standards under section 1834(a)(20) or delay in the receipt of advice from the program oversight committee established under subsection (c) shall not delay the implementation of the competitive acquisition program under this section.

(3) CONTENTS OF CONTRACT.—

(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

(C) DISCLOSURE OF SUBCONTRACTORS.—

(i) INITIAL DISCLOSURE.—Not later than 10 days after the date a supplier enters into a contract with the Secretary under this section, such supplier shall disclose to the Secretary, in a form and manner specified by the Secretary, the information on—

(I) each subcontracting relationship that such supplier has in furnishing items and services under the contract; and

(II) whether each such subcontractor meets the requirement of section 1834(a)(20)(F)(i), if applicable to such subcontractor.

(ii) SUBSEQUENT DISCLOSURE.—Not later than 10 days after such a supplier subsequently enters into a subcontracting relationship described in clause (i)(II), such supplier shall disclose to the Secretary, in such form and manner, the information described in subclauses (I) and (II) of clause (i).

(4) LIMIT ON NUMBER OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of individuals for such items or services in the geographic area covered under the contract on a timely basis.

(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

(5) PAYMENT.—

(A) IN GENERAL.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on bids submitted and accepted under this section for such items and services. Based on such bids the Secretary shall determine a single payment amount for each item or service in each competitive acquisition area.

(B) REDUCED BENEFICIARY COST-SHARING.—

(i) APPLICATION OF COINSURANCE.—Payment under this section for items and services shall be in an amount equal to 80 percent of the payment basis described in subparagraph (A).

(ii) APPLICATION OF DEDUCTIBLE.—Before applying clause (i), the individual shall be required to meet the deductible described in section 1833(b).

(C) PAYMENT ON ASSIGNMENT-RELATED BASIS.—Payment for any item or service furnished by the entity may only be made under this section on an assignment-related basis.

(D) CONSTRUCTION.—Nothing in this section shall be construed as precluding the use of an advanced beneficiary notice with respect to a competitively priced item and service.

(6) PARTICIPATING CONTRACTORS.—

(A) IN GENERAL.—Except as provided in subsection (a)(4), payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

(i) the contractor has submitted a bid for such items and services under this section; and

(ii) the Secretary has awarded a contract to the contractor for such items and services under this section.

(B) BID DEFINED.—In this section, the term "bid" means an offer to furnish an item or service for a particular price and time period that includes, where appropriate, any services that are attendant to the furnishing of the item or service.

(C) RULES FOR MERGERS AND ACQUISITIONS.—In applying subparagraph (A) to a contractor, the contractor shall include a successor entity in the case of a merger or acquisi-

tion, if the successor entity assumes such contract along with any liabilities that may have occurred thereunder.

(D) PROTECTION OF SMALL SUPPLIERS.—In developing procedures relating to bids and the awarding of contracts under this section, the Secretary shall take appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in the program under this section.

(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary may consider the clinical efficiency and value of specific items within codes, including whether some items have a greater therapeutic advantage to individuals.

(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH, AND COMPLAINT SERVICES.—The Secretary may enter into contracts with appropriate entities to address complaints from individuals who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such individuals and monitoring quality of services with respect to the program.

(9) AUTHORITY TO CONTRACT FOR IMPLEMENTATION.—The Secretary may contract with appropriate entities to implement the competitive bidding program under this section.

(10) SPECIAL RULE IN CASE OF COMPETITION FOR DIABETIC TESTING STRIPS.—

(A) IN GENERAL.—With respect to the competitive acquisition program for diabetic testing strips conducted after the first round of the competitive acquisition programs, if an entity does not demonstrate to the Secretary that its bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover 50 percent (or such higher percentage as the Secretary may specify) of all such types of products, the Secretary shall reject such bid. With respect to bids to furnish such types of products on or after January 1, 2019, the volume for such types of products shall be determined by the Secretary through the use of multiple sources of data (from mail order and non-mail order Medicare markets), including market-based data measuring sales of diabetic testing strip products that are not exclusively sold by a single retailer from such markets.

(B) STUDY OF TYPES OF TESTING STRIP PRODUCTS.—Before 2011, the Inspector General of the Department of Health and Human Services shall conduct a study to determine the types of diabetic testing strip products by volume that could be used to make determinations pursuant to subparagraph (A) for the first competition under the competitive acquisition program described in such subparagraph and submit to the Secretary a report on the results of the study. The Inspector General shall also conduct such a study and submit such a report before the Secretary conducts a subsequent competitive acquistion program described in subparagraph (A).

(C) DEMONSTRATION OF ABILITY TO FURNISH TYPES OF DIABETIC TESTING STRIP PRODUCTS.—With respect to bids to furnish diabetic testing strip products on or after January

1, 2019, an entity shall attest to the Secretary that the entity has the ability to obtain an inventory of the types and quantities of diabetic testing strip products that will allow the entity to furnish such products in a manner consistent with its bid and—

(i) demonstrate to the Secretary, through letters of intent with manufacturers, wholesalers, or other suppliers, or other evidence as the Secretary may specify, such ability; or

(ii) demonstrate to the Secretary that it made a good faith attempt to obtain such a letter of intent or such other evidence.

(D) USE OF UNLISTED TYPES IN CALCULATION OF PERCENTAGE.—With respect to bids to furnish diabetic testing strip products on or after January 1, 2019, in determining under subparagraph (A) whether a bid submitted by an entity under such subparagraph covers 50 percent (or such higher percentage as the Secretary may specify) of all types of diabetic testing strip products, the Secretary may not attribute a percentage to types of diabetic testing strip products that the Secretary does not identify by brand, model, and market share volume.

(E) ADHERENCE TO DEMONSTRATION.—

(i) IN GENERAL.—In the case of an entity that is furnishing diabetic testing strip products on or after January 1, 2019, under a contract entered into under the competition conducted pursuant to paragraph (1), the Secretary shall establish a process to monitor, on an ongoing basis, the extent to which such entity continues to cover the product types included in the entity's bid.

(ii) TERMINATION.—If the Secretary determines that an entity described in clause (i) fails to maintain in inventory, or otherwise maintain ready access to (through requirements, contracts, or otherwise) a type of product included in the entity's bid, the Secretary may terminate such contract unless the Secretary finds that the failure of the entity to maintain inventory of, or ready access to, the product is the result of the discontinuation of the product by the product manufacturer, a market-wide shortage of the product, or the introduction of a newer model or version of the product in the market involved.

(11) ADDITIONAL SPECIAL RULES IN CASE OF COMPETITION FOR DIABETIC TESTING STRIPS.—

(A) IN GENERAL.—With respect to an entity that is furnishing diabetic testing strip products to individuals under a contract entered into under the competitive acquisition program established under this section, the entity shall furnish to each individual a brand of such products that is compatible with the home blood glucose monitor selected by the individual.

(B) PROHIBITION ON INFLUENCING AND INCENTIVIZING.—An entity described in subparagraph (A) may not attempt to influence or incentivize an individual to switch the

brand of glucose monitor or diabetic testing strip product selected by the individual, including by—

(i) persuading, pressuring, or advising the individual to switch; or

(ii) furnishing information about alternative brands to the individual where the individual has not requested such information.

(C) PROVISION OF INFORMATION.—

(i) STANDARDIZED INFORMATION.—Not later than January 1, 2019, the Secretary shall develop and make available to entities described in subparagraph (A) standardized information that describes the rights of an individual with respect to such an entity. The information described in the preceding sentence shall include information regarding—

(I) the requirements established under subparagraphs (A) and (B);

(II) the right of the individual to purchase diabetic testing strip products from another mail order supplier of such products or a retail pharmacy if the entity is not able to furnish the brand of such product that is compatible with the home blood glucose monitor selected by the individual; and

(III) the right of the individual to return diabetic testing strip products furnished to the individual by the entity.

(ii) REQUIREMENT.—With respect to diabetic testing strip products furnished on or after the date on which the Secretary develops the standardized information under clause (i), an entity described in subparagraph (A) may not communicate directly to an individual until the entity has verbally provided the individual with such standardized information.

(D) ORDER REFILLS.—With respect to diabetic testing strip products furnished on or after January 1, 2019, the Secretary shall require an entity furnishing diabetic testing strip products to an individual to contact and receive a request from the individual for such products not more than 14 days prior to dispensing a refill of such products to the individual.

(12) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

(A) the establishment of payment amounts under paragraph (5);

(B) the awarding of contracts under this section;

(C) the designation of competitive acquisition areas under subsection (a)(1)(A) and the identification of areas under subsection (a)(1)(D)(iii);

(D) the phased-in implementation under subsection (a)(1)(B) and implementation of subsection (a)(1)(D);

(E) the selection of items and services for competitive acquisition under subsection (a)(2);

(F) the bidding structure and number of contractors selected under this section; or

(G) the implementation of the special rule described in paragraph (10).

(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

(1) ESTABLISHMENT.—The Secretary shall establish a Program Advisory and Oversight Committee (hereinafter in this section referred to as the "Committee").

(2) MEMBERSHIP; TERMS.—The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

(3) DUTIES.—

(A) ADVICE.—The Committee shall provide advice to the Secretary with respect to the following functions:

(i) The implementation of the program under this section.

(ii) The establishment of financial standards for purposes of subsection (b)(2)(A)(ii).

(iii) The establishment of requirements for collection of data for the efficient management of the program.

(iv) The development of proposals for efficient interaction among manufacturers, providers of services, suppliers (as defined in section 1861(d)), and individuals.

(v) The establishment of quality standards under section 1834(a)(20).

(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

(5) TERMINATION.—The Committee shall terminate on December 31, 2011.

(d) REPORT.—Not later than July 1, 2011, the Secretary shall submit to Congress a report on the programs under this section. The report shall include information on savings, reductions in cost-sharing, access to and quality of items and services, and satisfaction of individuals.

(f) COMPETITIVE ACQUISITION OMBUDSMAN.—The Secretary shall provide for a competitive acquisition ombudsman within the Centers for Medicare & Medicaid Services in order to respond to complaints and inquiries made by suppliers and individuals relating to the application of the competitive acquisition program under this section. The ombudsman may be within the office of the Medicare Beneficiary Ombudsman appointed under section 1808(c). The ombudsman shall submit to Congress an annual report on the activities under this subsection, which report shall be coordinated with the report provided under section 1808(c)(2)(C).

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PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (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 1834(b), 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 1834(b)(6)), 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 1834(b).

(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 schedule 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 services 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 applica-

tion of the payment adjustment under section 1848(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 3001(c)(5) of the Public Health Service Act. 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 1861(r).

(8) INCENTIVES FOR QUALITY REPORTING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional 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 pur-

poses 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 1834(b)(6)), the Secretary shall base the relative values on the relative value scale developed under section 1834(b)(1)(A), 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 1833(t) 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 this paragraph, 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 1861(eee)(4), 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 1833(t) 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 1861(eee)(3), 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 1861(eee)(4)(B).

(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 physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section 1861(aa)(5)(B)), or certified nurse midwife (as defined in section 1861(gg)(2)).

(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 title for such services; and

(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) 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 ap-

plication 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 furnishing 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; **[**and**]**

(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) the amendment made by section 2(d)(1) of the Medicare Vision Act of 2019 shall not be taken into account in applying clause (ii)(II) for 2022 and 2023.

(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).

(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 expenditures attributable to the multiple procedure pay-

ment 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 1834(p)

(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 reduced 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 title 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 per-

cent 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 title 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 administration 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 1842(o), 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 title 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 1847A or section 1847B, 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, United States Code, 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 1841, 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 determining 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 1841 $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 in-

volved. 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 1833(z)(2)) (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.

(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 es-

tablished 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 1842(i)(3)) 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 1842(i)(3)) 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 1842(i)(3)) 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 1842(i)(3)) 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) PERIDIC 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 elapsed 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, 2020, 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) 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

(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 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 1886(d)(3)(E)(iii)(II)) 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 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 1886(d)(5)(H).

(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 $\frac{5}{6}$; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus $\frac{1}{6}$.

(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 be-

ginning 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 title 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 1876.

(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 1842(i)(2)) 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 1842(j). 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 1834(b), 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 1842(j)(1)(C) 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 1842(b)(16)(B)(ii)), 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 1834(b), 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 1842(b)(4)(A)(iv)) 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 1905(p)(1)) with respect to such services under a State plan approved under title XIX may only be made on an assignment-related basis and the provisions of section 1902(n)(3)(A) 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 as-

signment-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 1842(j)(2).

(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 1842(b)(6)(A))—

(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 1842(b)(6)(A)) 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 1842(b)(6)(A)) 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 1842(p)(3) for a violation of section 1842(p)(1).

(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, of each year (beginning with 1991) 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 fur-

nishing physicians' services (as defined in section 1848(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 1842(h) (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 1869 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 1842(b)(3)(B) 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 1842(b)(8), and

(C) section 1842(b)(9) 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 (as defined by the Secretary and including anesthesia services), primary care services (as defined in section 1842(i)(4)), and all other physicians' services. The Secretary shall define surgical services and publish such definitions 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 1842(b) 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 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W), (2)(AA), (2)(DD), (2)(EE), (2)(FF) (including administration of the health risk assessment), *(2)(II),* (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) 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 the date of the enactment of this subsection, 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 1890(a).

(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 1890(a), 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.

(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 1842(b)(18)(C).

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

(iv) Beginning with 2009, a qualified audiologist (as defined in section 1861(ll)(3)(B)).

(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 1833(q)(1)), 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 1869, section 1878, or otherwise, of the development and implementation of the report-

ing 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 Sup-

plementary Medical Insurance Trust Fund under section 1841.

(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;

(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 1842(b)(6)) 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 1841 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; and

(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 1842(b)(6)) 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 1841 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 AND 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 furnishedduring 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 1860D-15(d)(2)(B) and 1860D-15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D-15 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 1860D–4(e).

(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 1866A.

(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 1890(b)(7) and 1890A(a) shall not apply; and

(II) measures endorsed by the entity with a contract with the Secretary under section 1890(a) 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 1833 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 288, 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 1869, section 1878, 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 termsin 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) 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), 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 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 success-

fully 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 Sec-

retary 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 title (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 title.

(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 title 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 title;

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

(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 title.

(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, United States Code.

(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) 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) available to the public.

(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

(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 1861(r)(1).

(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 1869, section 1878, 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 title.

(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 1842(b)(6)), from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 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 332(a)(1)(A) of the Public Health Service Act) 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 1833 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, anesthe-

siologist, 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 title and title XIX. The Secretary may also adjust the reporting periods under such title 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 sub-

section (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 1890(a).

(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 Sec-

retary 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 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 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), 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 1833(m) 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 1869, section 1878, 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 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act 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 1861(r).

(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 modi-

fier 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 1890(a).

(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) 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 January 1, 2015, and ending on December 31, 2016, the term "physician" has the meaning given such term in section 1861(r). 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 Sec-

retary determines appropriate, other similar provisions of this title.

(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, 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 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), a certified registered nurse anesthetist (as defined in section 1861(bb)(2)), 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 1833(z)(2));

(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 1833(z) 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 2021 and 2022—

(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 were instead references to 40 percent and 20 percent, respectively; and

(III) with respect to 2023 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 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 title 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 1833(z)) 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 appro-

priate, 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.

(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 1833(z)(3)(C)).

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 332(a)(1)(A) of the Public Health Service Act).

(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 1890(a).

(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 1890A 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 method-

ology 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 1833(z)(3)(C)) 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 re-

spect 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), anal-

ysis 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 increase 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 (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment 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 3012(c) of the Public Health Service Act), 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 section 332(a)(1)(A) of such Act), 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 1833(z)(3)(C).

(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 1841 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 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, United States Code.

(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.

(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 title 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 1899.

(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title 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 1869, section 1878, 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 1833(z), 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 the date of the enactment of this subsection, 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 title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title 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 the date of the

enactment of this subsection, 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 1869, section 1878, 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, United States Code, shall not apply to this section.

(9) DEFINITIONS.—In this subsection:

(A) PHYSICIAN.—The term "physician" has the meaning given such term in section 1861(r)(1).

(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 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); 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 1890(b)(7) and 1890A 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 title 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 1890(a) 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 title 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 1833(z)(3)(D).

(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 1841, 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, United States Code, shall not apply to the collection of information for the development of quality measures.

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PART E—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1).

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by subsection (s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

Inpatient Psychiatric Hospital Services

(c) The term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Supplier

(d) The term "supplier" means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician, except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical

nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1865(a), or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation

or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body.. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term "hospital" does not include, unless the context otherwise requires, a critical access hospital (as defined in section 1861(mm)(1)).

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (9) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A; and

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital".

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in paragraphs (3), (6) and (7)) by such skilled nursing facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical or occupational therapy or speech-language pathology services furnished by the skilled nursing facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (l)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements with them made by the facility;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.

Skilled Nursing Facility

(j) The term "skilled nursing facility" has the meaning given such term in section 1819(a).

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B)

for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (of which at least two must be physicians described in subsection (r)(1) of this section), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(l) A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining

whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical or occupational therapy or speech-language pathology services;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care, and a covered osteoporosis drug (as defined in subsection (kk)), but excluding other drugs and biologicals) and durable medical equipment and applicable disposable devices (as defined in section 1834(s)(2)) while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital and home infusion therapy (as defined in subsection (iii)(i)). For purposes of paragraphs (1) and (4), the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations) and eye tracking and gaze interaction accessories for speech generating devices furnished to individuals with a demonstrated medical need for such accessories; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including

one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z);

(6) meets the conditions of participation specified in section 1891(a) and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

(7) provides the Secretary with a surety bond—

(A) in a form specified by the Secretary and in an amount that is not less than the minimum of $50,000; and

(B) that the Secretary determines is commensurate with the volume of payments to the home health agency; and

(8) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in paragraph (1), (3), or (4) of section 1861(r)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established by a physician (as so defined) or by a qualified physical therapist and is periodically reviewed by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician. The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(1) and with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1847B);

(B) hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1881(b)(14)(B)), including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1881(b)(14) to an individual with acute kidney injury (as defined in section 1834(r)(2));

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

(H)(i) services furnished pursuant to a contract under section 1876 to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5)) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and

(ii) services furnished pursuant to a risk-sharing contract under section 1876(g) to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2)), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

(I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

(J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title;

(K)(i) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are per-

formed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,

(ii) services which would be physicians' services and services described in subsections (ww)(1) and (hhh) if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

(L) certified nurse-midwife services;

(M) qualified psychologist services;

(N) clinical social worker services (as defined in subsection (hh)(2));

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;

(P) prostate cancer screening tests (as defined in subsection (oo));

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp));

(S) diabetes outpatient self-management training services (as defined in subsection (qq));

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;

(U) screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;

(V) medical nutrition therapy services (as defined in subsection (vv)(1)) in the case of a beneficiary with diabetes or a renal disease who—

(i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary;

(ii) is not receiving maintenance dialysis for which payment is made under section 1881; and

(iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;

(W) an initial preventive physical examination (as defined in subsection (ww));

(X) cardiovascular screening blood tests (as defined in subsection (xx)(1));

(Y) diabetes screening tests (as defined in subsection (yy));

(Z) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));

(AA) ultrasound screening for abdominal aortic aneurysm (as defined in subsection (bbb)) for an individual—

(i) who receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (as defined in section 1861(ww)(1));

(ii) who has not been previously furnished such an ultrasound screening under this title; and

(iii) who—

(I) has a family history of abdominal aortic aneurysm; or

(II) manifests risk factors included in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding abdominal aortic aneurysms;

(BB) additional preventive services (described in subsection (ddd)(1));

(CC) items and services furnished under a cardiac rehabilitation program (as defined in subsection (eee)(1)) or under a pulmonary rehabilitation program (as defined in subsection (fff)(1));

(DD) items and services furnished under an intensive cardiac rehabilitation program (as defined in subsection (eee)(4));

(EE) kidney disease education services (as defined in subsection (ggg));

(FF) personalized prevention plan services (as defined in subsection (hhh));

(GG) home infusion therapy (as defined in subsection (iii)(1)); [and]

(HH) opioid use disorder treatment services (as defined in subsection (jjj))**[.]***; and*

(II) vision services (as defined in subsection (kkk));

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but, subject to section 1834(l)(14), only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices**[**, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens**]***, including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens, if furnished before January 1, 2022, and including conventional eyeglasses or contact lenses, whether or not furnished subsequent to such a surgery, if furnished on or after January 1, 2022*;

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10)(A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration; and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb));

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such

shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);

(13) screening mammography (as defined in subsection (jj));

(14) screening pap smear and screening pelvic exam; and

(15) bone mass measurement (as defined in subsection (rr)).

No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(17)(A) meets the certification requirements under section 353 of the Public Health Service Act; and

(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t)(1) The term "drugs" and the term "biologicals", except for purposes of subsection (m)(5) and paragraph (2), include only such drugs (including contrast agents) and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2)(A) For purposes of paragraph (1), the term "drugs" also includes any drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication (as described in subparagraph (B)).

(B) In subparagraph (A), the term "medically accepted indication", with respect to the use of a drug, includes any use which has been approved by the Food and Drug Administration for the drug, and includes another use of the drug if—

(i) the drug has been approved by the Food and Drug Administration; and

(ii)(I) such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information (or its successor publications), and other authoritative compendia as identified by the Secretary, unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia, or

(II) the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this subclause by the Secretary.

The Secretary may revise the list of compendia in clause (ii)(I) as is appropriate for identifying medically accepted indications for drugs. On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Provider of Services

(u) The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in com-

puting the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) In the case of extended care services, the regulations under subparagraph (A) shall not include provision for specific recognition of a return on equity capital.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if—

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the

cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1819 (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality improvement organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

(ii)(I) Except as provided in subclause (II), the payment rate referred to in clause (i) is a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved under title XIX for the State in which such hospital is located, or, if the State in which the hospital is located does not have a State plan approved under title XIX, the estimated adjusted State-wide average allowable costs per patient-day for extended care services under this title in that State.

(II) If a hospital has a unit which is a skilled nursing facility, the payment rate referred to in clause (i) for the hospital is a rate equal to the lesser of the rate described in subclause (I) or the allowable costs in effect under this title for extended care services provided to patients of such unit.

(iii) Any day on which an individual receives inpatient services for which payment is made under this subparagraph shall, for purposes of this Act (other than this subparagraph), be deemed to be a day on which the individual received inpatient hospital services.

(iv) In determining under clause (i), in the case of a public hospital, whether or not there is an excess of hospital beds in the area of such hospital, such determination shall be made on the basis of only the public hospitals (including the hospital) which are in the area of the hospital and which are under common ownership with that hospital.

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8);

(ii) in the case of home health agencies to which the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8) apply, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

(iii) in the case of contracts entered into by a home health agency after the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any such contract which is entered into for a period exceeding five years; and

(iv) in the case of contracts entered into by a home health agency before the date of the enactment of this subparagraph for the purpose of having services furnished for or on behalf of such agency, any cost incurred by such agency pursuant to any

such contract, which determines the amount payable by the home health agency on the basis of a percentage of the agency's reimbursement or claim for reimbursement for services furnished by the agency, to the extent that such cost exceeds the reasonable value of the services furnished on behalf of such agency.

(I) In determining such reasonable cost, the Secretary may not include any costs incurred by a provider with respect to any services furnished in connection with matters for which payment may be made under this title and furnished pursuant to a contract between the provider and any of its subcontractors which is entered into after the date of the enactment of this subparagraph and the value or cost of which is $10,000 or more over a twelve-month period unless the contract contains a clause to the effect that—

(i) until the expiration of four years after the furnishing of such services pursuant to such contract, the subcontractor shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the contract, and books, documents and records of such subcontractor that are necessary to certify the nature and extent of such costs, and

(ii) if the subcontractor carries out any of the duties of the contract through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request by the Secretary, or upon request by the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

The Secretary shall prescribe in regulation criteria and procedures which the Secretary shall use in obtaining access to books, documents, and records under clauses required in contracts and subcontracts under this subparagraph.

(J) Such regulations may not provide for any inpatient routine salary cost differential as a reimbursable cost for hospitals and skilled nursing facilities.

(K)(i) The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals (other than bona fide emergency services as defined in clause (ii)) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this title.

(ii) For purposes of clause (i), the term "bona fide emergency services" means services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by

acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(I) placing the patient's health in serious jeopardy;

(II) serious impairment to bodily functions; or

(III) serious dysfunction of any bodily organ or part.

(L)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies,

(II) July 1, 1986, and before July 1, 1987, 115 percent of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent of such mean,

(IV) October 1, 1997, and before October 1, 1998, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies, or

(V) October 1, 1998, 106 percent of such median.

(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis. The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, subject to clause (viii)(I), the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during fiscal year 1994, and based 25 percent on 98 percent of the standardized regional average of such costs for the agency's census division, as applied to such agency, for cost reporting periods ending during fiscal year 1994, such costs updated by the home health market basket index; and

(II) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994 subject to clauses (viii)(II) and (viii)(III), the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.

(viii)(I) In the case of a provider with a 12-month cost reporting period ending in fiscal year 1994, if the limit imposed under clause (v) (determined without regard to this subclause) for a cost reporting period beginning during or after fiscal year 1999 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by ⅓ of such difference.

(II) Subject to subclause (IV), for new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, for cost reporting periods beginning during or after fiscal year 1999, the per beneficiary limitation described in clause (vi)(I) shall be equal to the median described in such clause (determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent").

(III) Subject to subclause (IV), in the case of a new provider for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in clause (vi)(I).

(IV) In the case of a new provider or a provider without a 12-month cost reporting period ending in fiscal year 1994, subclause (II) shall apply, instead of subclause (III), to a home health agency which filed an application for home health agency provider status under this title before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

(V) Each of the amounts specified in subclauses (I) through (III) are such amounts as adjusted under clause (iii) to reflect variations in wages among different areas.

(ix) Notwithstanding the per beneficiary limit under clause (viii), if the limit imposed under clause (v) (determined without regard to this clause) for a cost reporting period beginning during or after fiscal year 2000 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to "98 percent" were a reference to "100 percent"), the limit otherwise imposed under clause (v) for such provider and period shall be increased by 2 percent.

(x) Notwithstanding any other provision of this subparagraph, in updating any limit under this subparagraph by a home health market basket index for cost reporting periods beginning during each of fiscal years 2000, 2002, and 2003, the update otherwise provided shall be reduced by 1.1 percentage points. With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket index.

(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs.

(N) In determining such reasonable costs, costs incurred for activities directly related to influencing employees respecting unionization may not be included.

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a provider of services which has undergone a change of ownership, such regulations shall provide, except as provided in clause (iii), that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).

(ii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this title.

(iii) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner

shall be the book value of the hospital to the State at the time of the transfer.

(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.

(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1869(b) shall not be allowable as reasonable costs.

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1833(t) is implemented.

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1833(t) is implemented.

(III) Subclauses (I) and (II) shall not apply to payments with respect to the costs of hospital outpatient services provided by any hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) or a critical access hospital (as defined in section 1861(mm)(1)).

(IV) In applying subclauses (I) and (II) to services for which payment is made on the basis of a blend amount under section 1833(i)(3)(A)(ii) or 1833(n)(1)(A)(ii), the costs reflected in the amounts described in sections 1833(i)(3)(B)(i)(I) and 1833(n)(1)(B)(i)(I), respectively, shall be reduced in accordance with such subclause.

(T) In determining such reasonable costs for hospitals, no reduction in copayments under section 1833(t)(8)(B) shall be treated as a bad debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable,

(iii) for cost reporting periods beginning during fiscal year 2000, by 45 percent of such amount otherwise allowable,

(iv) for cost reporting periods beginning during fiscal years 2001 through 2012, by 30 percent of such amount otherwise allowable, and

(v) for cost reporting periods beginning during fiscal year 2013 or a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. For ambulance services provided after June 30, 1998, the Secretary may provide that claims for such services must include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(V) In determining such reasonable costs for skilled nursing facilities and (beginning with respect to cost reporting periods beginning during fiscal year 2013) for covered skilled nursing services described in section 1888(e)(2)(A) furnished by hospital providers of extended care services (as described in section 1883), the amount of bad debts otherwise treated as allowed costs which are attributable to the coinsurance amounts under this title for individuals who are entitled to benefits under part A and—

(i) are not described in section 1935(c)(6)(A)(ii) shall be reduced by—

(I) for cost reporting periods beginning on or after October 1, 2005, but before fiscal year 2013, 30 percent of such amount otherwise allowable; and

(II) for cost reporting periods beginning during fiscal year 2013 or a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(ii) are described in such section—

(I) for cost reporting periods beginning on or after October 1, 2005, but before fiscal year 2013, shall not be reduced;

(II) for cost reporting periods beginning during fiscal year 2013, shall be reduced by 12 percent of such amount otherwise allowable;

(III) for cost reporting periods beginning during fiscal year 2014, shall be reduced by 24 percent of such amount otherwise allowable; and

(IV) for cost reporting periods beginning during a subsequent fiscal year, shall be reduced by 35 percent of such amount otherwise allowable.

(W)(i) In determining such reasonable costs for providers described in clause (ii), the amount of bad debts otherwise treated as allowable costs which are attributable to deductibles and coinsurance amounts under this title shall be reduced—

(I) for cost reporting periods beginning during fiscal year 2013, by 12 percent of such amount otherwise allowable;

(II) for cost reporting periods beginning during fiscal year 2014, by 24 percent of such amount otherwise allowable; and

(III) for cost reporting periods beginning during a subsequent fiscal year, by 35 percent of such amount otherwise allowable.

(ii) A provider described in this clause is a provider of services not described in subparagraph (T) or (V), a supplier, or any other type of entity that receives payment for bad debts under the authority under subparagraph (A).

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866(a)(2)(B)(ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges ex-

ceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of subsection (p) (including through the operation of subsection (g)) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7)(A) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(B) For further limitations on reasonable cost and determination of payment amounts for operating costs of inpatient hospital services and waivers for certain States, see section 1886.

(C) For provisions restricting payment for provider-based physicians' services and for payments under certain percentage arrangements, see section 1887.

(D) For further limitations on reasonable cost and determination of payment amounts for routine service costs of skilled nursing facilities, see subsections (a) through (c) of section 1888.

(8) ITEMS UNRELATED TO PATIENT CARE.—Reasonable costs do not include costs for the following—

(i) entertainment, including tickets to sporting and other entertainment events;

(ii) gifts or donations;

(iii) personal use of motor vehicles;

(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

(v) education expenses for spouses or other dependents of providers of services, their employees or contractors.

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital or critical access hospital to patients insured under part A of this title or entitled to have payment made for such services under part B of this title or under a State plan approved under title XIX, by a quality improvement organization designated for the area in which such hospital or critical access hospital is located shall be deemed to have been conducted pursuant to arrangements between such hospital or critical access hospital and such organization under which such hospital or critical access hospital is obligated to pay to such organization, as a condition of receiving payment for hospital or critical access hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital or critical access hospital to such patients.

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 210.

Extended Care in Religious Nonmedical Health Care Institutions

(y)(1) The term "skilled nursing facility" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

Institutional Planning

(z) An overall plan and budget of a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2)(A) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $600,000 (or such lesser amount as may be established by the State under section 1122(g)(1) in which the hospital is located) related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(B) provides that such plan is submitted to the agency designated under section 1122(b), or if no such agency is designated, to the appropriate health planning agency in the State (but this subparagraph shall not apply in the case of a facility exempt from review under section 1122 by reason of section 1122(j));

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

Rural Health Clinic Services and Federally Qualified Health Center Services

(aa)(1) The term "rural health clinic services" means —

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10),

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1)), and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which —

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diag-

nostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify;

(J) has a nurse practitioner, a physician assistant, or a certified nurse-midwife (as defined in subsection (gg)) available to furnish patient care services not less than 50 percent of the time the clinic operates; and

(K) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), and that, within the previous 4-year period, has been designated by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act, (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, of (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections

(a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

(3) The term "Federally qualified health center services" means—

(A) services of the type described in subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and

(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act,

when furnished to an individual as an outpatient of a Federally qualified health center by the center or by a health care professional under contract with the center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

(4) The term "Federally qualified health center" means an entity which—

(A)(i) is receiving a grant under section 330 of the Public Health Service Act, or

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act;

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

(5)(A) The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such

training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term "clinical nurse specialist" means, for purposes of this title, an individual who—

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

(6) The term "collaboration" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received.

Services of a Certified Registered Nurse Anesthetist

(bb)(1) The term "services of a certified registered nurse anesthetist" means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

(2) The term "certified registered nurse anesthetist" means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) The term "comprehensive outpatient rehabilitation facility services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient

of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech-language pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies and durable medical equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this title.

(2) The term "comprehensive outpatient rehabilitation facility" means a facility which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standards established for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z);

(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and

(J) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

The Secretary may waive the requirement of a surety bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.

Hospice Care; Hospice Program

(dd)(1) The term "hospice care" means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) nursing care provided by or under the supervision of a registered professional nurse,

(B) physical or occupational therapy, or speech-language pathology services,

(C) medical social services under the direction of a physician,

(D)(i) services of a home health aide who has successfully completed a training program approved by the Secretary and (ii) homemaker services,

(E) medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,

(F) physicians' services,

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and

(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals and services described in section 1812(a)(5),

(ii) provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), and (H) of paragraph (1), except as otherwise provided in paragraph (5), and

(II) in the case of other services described in paragraph (1) which are not provided directly by the agency or organization, the agency or organization must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished; and

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section 1812(d) with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1)),

(II) one registered professional nurse, and

(III) one social worker,

employed by or, in the case of a physician described in subclause (I), under contract with the agency or organization, and also includes at least one pastoral or other counselor,

(ii) provides (or supervises the provision of) the care and services described in paragraph (1), and

(iii) establishes the policies governing the provision of such care and services;

(C) maintains central clinical records on all patients;

(D) does not discontinue the hospice care it provides with respect to a patient because of the inability of the patient to pay for such care;

(E)(i) utilizes volunteers in its provision of care and services in accordance with standards set by the Secretary, which standards shall ensure a continuing level of effort to utilize such volunteers, and (ii) maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers;

(F) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law; and

(G) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

(3)(A) An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

(B) The term "attending physician" means, with respect to an individual, the physician (as defined in subsection (r)(1)), the nurse practitioner (as defined in subsection (aa)(5)), or the physician assistant (as defined in such subsection), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

(4)(A) An entity which is certified as a provider of services other than a hospice program shall be considered, for purposes of certification as a hospice program, to have met any requirements under paragraph (2) which are also the same requirements for certification as such other type of provider. The Secretary shall coordinate surveys for determining certification under this title so as to provide, to the extent feasible, for simultaneous surveys of an entity which seeks to be certified as a hospice program and as a provider of services of another type.

(B) Any entity which is certified as a hospice program and as a provider of another type shall have separate provider agreements under section 1866 and shall file separate cost reports with respect to costs incurred in providing hospice care and in providing other services and items under this title.

(C) Any entity that is certified as a hospice program shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months beginning 6 months after the date of the enactment of this subparagraph and ending September 30, 2025.

(5)(A) The Secretary may waive the requirements of paragraph (2)(A)(ii)(I) for an agency or organization with respect to all or part of the nursing care described in paragraph (1)(A) if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of the Census);

(ii) was in operation on or before January 1, 1983; and

(iii) has demonstrated a good faith effort (as determined by the Secretary) to hire a sufficient number of nurses to provide such nursing care directly.

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A) or (C), shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) or (C) shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.

(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.

Discharge Planning Process

(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides.

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(H) Consistent with section 1802, the discharge plan shall—

(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.

(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

(B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan.

Partial Hospitalization Services

(ff)(1) The term "partial hospitalization services" means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

(2) The items and services described in this paragraph are—

(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

(B) occupational therapy requiring the skills of a qualified occupational therapist,

(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

(E) individualized activity therapies that are not primarily recreational or diversionary,

(F) family counseling (the primary purpose of which is treatment of the individual's condition),

(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment),

(H) diagnostic services, and

(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(3)(A) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual's home or in an inpatient or residential setting.

(B) For purposes of subparagraph (A), the term "community mental health center" means an entity that—

(i)(I) provides the mental health services described in section 1913(c)(1) of the Public Health Service Act; or

(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located;

(iii) provides at least 40 percent of its services to individuals who are not eligible for benefits under this title; and

(iv) meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act.

Certified Nurse-Midwife Services

(gg)(1) The term "certified nurse-midwife services" means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to the nurse-midwife's service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physicians' service.

(2) The term "certified nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary.

Clinical Social Worker; Clinical Social Worker Services

(hh)(1) The term "clinical social worker" means an individual who—

(A) possesses a master's or doctor's degree in social work;

(B) after obtaining such degree has performed at least 2 years of supervised clinical social work; and

(C)(i) is licensed or certified as a clinical social worker by the State in which the services are performed, or

(ii) in the case of an individual in a State which does not provide for licensure or certification—

(I) has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

(II) meets such other criteria as the Secretary establishes.

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

Qualified Psychologist Services

(ii) The term "qualified psychologist services" means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

Screening Mammography

(jj) The term "screening mammography" means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.

Covered Osteoporosis Drug

(kk) The term "covered osteoporosis drug" means an injectable drug approved for the treatment of post-menopausal osteoporosis provided to an individual by a home health agency if, in accordance with regulations promulgated by the Secretary—

(1) the individual's attending physician certifies that the individual has suffered a bone fracture related to post-menopausal osteoporosis and that the individual is unable to learn the skills needed to self-administer such drug or is otherwise

physically or mentally incapable of self-administering such drug; and

(2) the individual is confined to the individual's home (except when receiving items and services referred to in subsection (m)(7)).

Speech-Language Pathology Services; Audiology Services

(ll)(1) The term "speech-language pathology services" means such speech, language, and related function assessment and rehabilitation services furnished by a qualified speech-language pathologist as the speech-language pathologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician.

(2) The term "outpatient speech-language pathology services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that in applying such subsection—

(A) "speech-language pathology" shall be substituted for "physical therapy" each place it appears; and

(B) "speech-language pathologist" shall be substituted for "physical therapist" each place it appears.

(3) The term "audiology services" means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

(4) In this subsection:

(A) The term "qualified speech-language pathologist" means an individual with a master's or doctoral degree in speech-language pathology who—

(i) is licensed as a speech-language pathologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license speech-language pathologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed a national examination in speech-language pathology approved by the Secretary.

(B) The term "qualified audiologist" means an individual with a master's or doctoral degree in audiology who—

(i) is licensed as an audiologist by the State in which the individual furnishes such services, or

(ii) in the case of an individual who furnishes services in a State which does not license audiologists, has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), performed not less than 9 months of supervised full-time audiology services after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary.

Critical Access Hospital; Critical Access Hospital Services

(mm)(1) The term "critical access hospital" means a facility certified by the Secretary as a critical access hospital under section 1820(e).

(2) The term "inpatient critical access hospital services" means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

(3) The term "outpatient critical access hospital services" means medical and other health services furnished by a critical access hospital on an outpatient basis.

Screening Pap Smear; Screening Pelvic Exam

(nn)(1) The term "screening pap smear" means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and includes a physician's interpretation of the results of the test, if the individual involved has not had such a test during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3).

(2) The term "screening pelvic exam" means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 2 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

(3) A woman described in this paragraph is a woman who—

(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).

Prostate Cancer Screening Tests

(oo)(1) The term "prostate cancer screening test" means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate-specific antigen blood test.

(C) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

Colorectal Cancer Screening Tests

(pp)(1) The term "colorectal cancer screening test" means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) Screening fecal-occult blood test.

(B) Screening flexible sigmoidoscopy.

(C) Screening colonoscopy.

(D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) An "individual at high risk for colorectal cancer" is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

Diabetes Outpatient Self-Management Training Services

(qq)(1) The term "diabetes outpatient self-management training services" means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

(2) In paragraph (1)—

(A) a "certified provider" is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.

Bone Mass Measurement

(rr)(1) The term "bone mass measurement" means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass

or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

(2) For purposes of this subsection, the term "qualified individual" means an individual who is (in accordance with regulations prescribed by the Secretary)—

(A) an estrogen-deficient woman at clinical risk for osteoporosis;

(B) an individual with vertebral abnormalities;

(C) an individual receiving long-term glucocorticoid steroid therapy;

(D) an individual with primary hyperparathyroidism; or

(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.

Religious Nonmedical Health Care Institution

(ss)(1) The term "religious nonmedical health care institution" means an institution that—

(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

(G)(i) is not owned by, under common ownership with, or has an ownership interest in, a provider of medical treatment or services;

(ii) is not affiliated with—

(I) a provider of medical treatment or services, or

(II) an individual who has an ownership interest in a provider of medical treatment or services;

(H) has in effect a utilization review plan which—

(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

(ii) requires that such reviews be made by an appropriate committee of the institution that includes the

individuals responsible for overall administration and for supervision of nursing personnel at the institution,

(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

(I) provides the Secretary with such information as the Secretary may require to implement section 1821, including information relating to quality of care and coverage determinations; and

(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.

(4)(A) For purposes of paragraph (1)(G)(i), an ownership interest of less than 5 percent shall not be taken into account.

(B) For purposes of paragraph (1)(G)(ii), none of the following shall be considered to create an affiliation:

(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.

Post-Institutional Home Health Services; Home Health Spell of Illness

(tt)(1) The term "post-institutional home health services" means home health services furnished to an individual—

(A) after discharge from a hospital or critical access hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

(2) The term "home health spell of illness" with respect to any individual means a period of consecutive days—

(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.

Screening for Glaucoma

(uu) The term "screening for glaucoma" means a dilated eye examination with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination for the early detection of glaucoma which is furnished by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, if the individual involved has not had such an examination in the preceding year.

Medical Nutrition Therapy Services; Registered Dietitian or Nutrition Professional

(vv)(1) The term "medical nutrition therapy services" means nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional (as defined in paragraph (2)) pursuant to a referral by a physician (as defined in subsection (r)(1)).

(2) Subject to paragraph (3), the term "registered dietitian or nutrition professional" means an individual who—

(A) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States

(or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized by the Secretary for this purpose;

(B) has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional; and

(C)(i) is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed; or

(ii) in the case of an individual in a State that does not provide for such licensure or certification, meets such other criteria as the Secretary establishes.

(3) Subparagraphs (A) and (B) of paragraph (2) shall not apply in the case of an individual who, as of the date of the enactment of this subsection, is licensed or certified as a dietitian or nutrition professional by the State in which medical nutrition therapy services are performed.

Initial Preventive Physical Examination

(ww)(1) The term "initial preventive physical examination" means physicians' services consisting of a physical examination (including measurement of height, weight body mass index,, and blood pressure) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), end-of-life planning (as defined in paragraph (3)) upon the agreement with the individual, and the furnishing of a review of any current opioid prescriptions (as defined in paragraph (4)), but does not include clinical laboratory tests.

(2) The screening and other preventive services described in this paragraph include the following:

(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

(B) Screening mammography as defined in subsection (jj).

(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

(D) Prostate cancer screening tests as defined in subsection (oo).

(E) Colorectal cancer screening tests as defined in subsection (pp).

(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

(G) Bone mass measurement as defined in subsection (rr).

(H) Screening for glaucoma as defined in subsection (uu).

(I) Medical nutrition therapy services as defined in subsection (vv).

(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

(K) Diabetes screening tests as defined in subsection (yy).

(L) Ultrasound screening for abdominal aortic aneurysm as defined in section 1861(bbb).

(M) An electrocardiogram.

(N) Screening for potential substance use disorders.

(O) Additional preventive services (as defined in subsection (ddd)(1)).

(3) For purposes of paragraph (1), the term "end-of-life planning" means verbal or written information regarding—

(A) an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and

(B) whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

(4) For purposes of paragraph (1), the term "a review of any current opioid prescriptions" means, with respect to an individual determined to have a current prescription for opioids—

(A) a review of the potential risk factors to the individual for opioid use disorder;

(B) an evaluation of the individual's severity of pain and current treatment plan;

(C) the provision of information on non-opioid treatment options; and

(D) a referral to a specialist, as appropriate.

Cardiovascular Screening Blood Test

(xx)(1) The term "cardiovascular screening blood test" means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

(A) Cholesterol levels and other lipid or triglyceride levels.

(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.

Diabetes Screening Tests

(yy)(1) The term "diabetes screening tests" means testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

(A) a fasting plasma glucose test; and

(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

(2) For purposes of paragraph (1), the term "individual at risk for diabetes" means an individual who has any of the following risk factors for diabetes:

(A) Hypertension.

(B) Dyslipidemia.

(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.

(D) Previous identification of an elevated impaired fasting glucose.

(E) Previous identification of impaired glucose tolerance.

(F) A risk factor consisting of at least 2 of the following characteristics:

(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2.

(ii) A family history of diabetes.

(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(iv) 65 years of age or older.

(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

Intravenous Immune Globulin

(zz) The term "intravenous immune globulin" means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.

Extended Care in Religious Nonmedical Health Care Institutions

(aaa)(1) The term "home health agency" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821.

(B) Notwithstanding any other provision of this title, payment may not be made under subparagraph (A)—

(i) in a year insofar as such payments exceed $700,000; and

(ii) after December 31, 2006.

Ultrasound Screening for Abdominal Aortic Aneurysm

(bbb) The term "ultrasound screening for abdominal aortic aneurysm" means—

(1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, that the Secretary may specify) provided for the early detection of abdominal aortic aneurysm; and

(2) includes a physician's interpretation of the results of the procedure.

Long-Term Care Hospital

(ccc) The term "long-term care hospital" means a hospital which—

(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

(2) has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or meets the requirements of clause (II) of section 1886(d)(1)(B)(iv);

(3) satisfies the requirements of subsection (e); and

(4) meets the following facility criteria:

(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary; and

(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient.

Additional Preventive Services; Preventive Services

(ddd)(1) The term "additional preventive services" means services not described in subparagraph (A) or (C) of paragraph (3) that identify medical conditions or risk factors and that the Secretary determines are—

(A) reasonable and necessary for the prevention or early detection of an illness or disability;

(B) recommended with a grade of A or B by the United States Preventive Services Task Force; and

(C) appropriate for individuals entitled to benefits under part A or enrolled under part B.

(2) In making determinations under paragraph (1) regarding the coverage of a new service, the Secretary shall use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title. As part of the use of such process, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such service and may take into account the results of such assessment in making such determination.

(3) The term "preventive services" means the following:

(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

(B) An initial preventive physical examination (as defined in subsection (ww)).

(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).

Cardiac Rehabilitation Program; Intensive Cardiac Rehabilitation Program

(eee)(1) The term "cardiac rehabilitation program" means a program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)).

(2) A program described in this paragraph is a program under which—

(A) items and services under the program are delivered—

(i) in a physician's office;

(ii) in a hospital on an outpatient basis; or

(iii) in other settings determined appropriate by the Secretary;

(B) a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)) is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and services furnished under such a program in a hospital, such availability shall be presumed; and

(C) individualized treatment is furnished under a written plan established, reviewed, and signed by a physician every 30 days that describes—

(i) the individual's diagnosis;

(ii) the type, amount, frequency, and duration of the items and services furnished under the plan; and

(iii) the goals set for the individual under the plan.

(3) The items and services described in this paragraph are—

(A) physician-prescribed exercise;

(B) cardiac risk factor modification, including education, counseling, and behavioral intervention (to the extent such education, counseling, and behavioral intervention is closely related to the individual's care and treatment and is tailored to the individual's needs);

(C) psychosocial assessment;

(D) outcomes assessment; and

(E) such other items and services as the Secretary may determine, but only if such items and services are—

(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

(4)(A) The term "intensive cardiac rehabilitation program" means a program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)) and has shown, in peer-reviewed published research, that it accomplished—

(i) one or more of the following:

(I) positively affected the progression of coronary heart disease; or

(II) reduced the need for coronary bypass surgery; or

(III) reduced the need for percutaneous coronary interventions; and

(ii) a statistically significant reduction in 5 or more of the following measures from their level before receipt of cardiac rehabilitation services to their level after receipt of such services:

(I) low density lipoprotein;

(II) triglycerides;

(III) body mass index;

(IV) systolic blood pressure;

(V) diastolic blood pressure; or

(VI) the need for cholesterol, blood pressure, and diabetes medications.

(B) To be eligible for an intensive cardiac rehabilitation program, an individual must have—

(i) had an acute myocardial infarction within the preceding 12 months;

(ii) had coronary bypass surgery;

(iii) stable angina pectoris;

(iv) had heart valve repair or replacement;

(v) had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;

(vi) had a heart or heart-lung transplant;

(vii) stable, chronic heart failure (defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks); or

(viii) any additional condition for which the Secretary has determined that a cardiac rehabilitation program shall be covered, unless the Secretary determines, using the same process used to determine that the condition is covered for a cardiac rehabilitation program, that such coverage is not supported by the clinical evidence.

(C) An intensive cardiac rehabilitation program may be provided in a series of 72 one-hour sessions (as defined in section 1848(b)(5)), up to 6 sessions per day, over a period of up to 18 weeks.

(5) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with car-

diac pathophysiology who is licensed to practice medicine in the State in which a cardiac rehabilitation program (or the intensive cardiac rehabilitation program, as the case may be) is offered—

(A) is responsible for such program; and

(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual in the program.

Pulmonary Rehabilitation Program

(fff)(1) The term "pulmonary rehabilitation program" means a program (as described in subsection (eee)(2) with respect to a program under this subsection) that furnishes the items and services described in paragraph (2) under the supervision of a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)).

(2) The items and services described in this paragraph are—

(A) physician-prescribed exercise;

(B) education or training (to the extent the education or training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs);

(C) psychosocial assessment;

(D) outcomes assessment; and

(E) such other items and services as the Secretary may determine, but only if such items and services are—

(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

(3) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with respiratory pathophysiology who is licensed to practice medicine in the State in which a pulmonary rehabilitation program is offered—

(A) is responsible for such program; and

(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual in the program.

Kidney Disease Education Services

(ggg)(1) The term "kidney disease education services" means educational services that are—

(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

(C) designed—

(i) to provide comprehensive information (consistent with the standards set under paragraph (3)) regarding—

(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

(II) the prevention of uremic complications; and

(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center as well as vascular access options and transplantation);

(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

(iii) to be tailored to meet the needs of the individual involved.

(2)(A) The term "qualified person" means—

(i) a physician (as defined in section 1861(r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)), who furnishes services for which payment may be made under the fee schedule established under section 1848; and

(ii) a provider of services located in a rural area (as defined in section 1886(d)(2)(D)).

(B) Such term does not include a provider of services (other than a provider of services described in subparagraph (A)(ii)) or a renal dialysis facility.

(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons. To the extent possible the Secretary shall consult with persons or entities described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

(4) No individual shall be furnished more than 6 sessions of kidney disease education services under this title.

Annual Wellness Visit

(hhh)(1) The term "personalized prevention plan services" means the creation of a plan for an individual—

(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (3); and

(B) that—

(i) takes into account the results of the health risk assessment; and

(ii) may contain the elements described in paragraph (2).

(2) Subject to paragraph (4)(H), the elements described in this paragraph are the following:

(A) The establishment of, or an update to, the individual's medical and family history.

(B) A list of current providers and suppliers that are regularly involved in providing medical care to the individual (including a list of all prescribed medications).

(C) A measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

(D) Detection of any cognitive impairment.

(E) The establishment of, or an update to, the following:

(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered under this title.

(ii) A list of risk factors and conditions for which primary, secondary, or tertiary prevention interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (as described under subsection (ww)(1)), and a list of treatment options and their associated risks and benefits.

(F) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

(G) Screening for potential substance use disorders and referral for treatment as appropriate.

(H) The furnishing of a review of any current opioid prescriptions (as defined in subsection (ww)(4)).

(I) Any other element determined appropriate by the Secretary.

(3) A health professional described in this paragraph is—

(A) a physician;

(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

(4)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

(ii) may be furnished—

(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B);

(II) during an encounter with a health care professional;

(III) through community-based prevention programs; or

(IV) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

(B) Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I). The Secretary may utilize any health risk assessment developed under section 4004(f) of the Patient Protection and Affordable Care Act as part of the requirement to develop a personalized prevention plan to comply with this subparagraph.

(C)(i) Not later than 18 months after the date of enactment of this subsection, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(D) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

(E) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

(F) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (ww)(1)) during the 12-month period after the date that the beneficiary's coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.

(H) The Secretary shall issue guidance that—

(i) identifies elements under paragraph (2) that are required to be provided to a beneficiary as part of their first visit for personalized prevention plan services; and

(ii) establishes a yearly schedule for appropriate provision of such elements thereafter.

(iii) HOME INFUSION THERAPY.—(1) The term "home infusion therapy" means the items and services described in paragraph (2) furnished by a qualified home infusion therapy supplier (as defined in paragraph (3)(D)) which are furnished in the individual's home (as defined in paragraph (3)(B)) to an individual—

(A) who is under the care of an applicable provider (as defined in paragraph (3)(A)); and

(B) with respect to whom a plan prescribing the type, amount, and duration of infusion therapy services that are to be furnished such individual has been established by a physician (as defined in subsection (r)(1)) and is periodically reviewed by a physician (as so defined) in coordination with the furnishing of home infusion drugs (as defined in paragraph (3)(C)) under part B.

(2) The items and services described in this paragraph are the following:

(A) Professional services, including nursing services, furnished in accordance with the plan.

(B) Training and education (not otherwise paid for as durable medical equipment (as defined in subsection (n)), remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

(3) For purposes of this subsection:

(A) The term "applicable provider" means—

(i) a physician;

(ii) a nurse practitioner; and

(iii) a physician assistant.

(B) The term "home" means a place of residence used as the home of an individual (as defined for purposes of subsection (n)).

(C) The term "home infusion drug" means a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in subsection (n)). Such term does not include the following:

(i) Insulin pump systems.

(ii) A self-administered drug or biological on a self-administered drug exclusion list.

(D)(i) The term "qualified home infusion therapy supplier" means a pharmacy, physician, or other provider of services or supplier licensed by the State in which the pharmacy, physician, or provider or services or supplier furnishes items or services and that—

(I) furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs;

(II) ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis;

(III) is accredited by an organization designated by the Secretary pursuant to section 1834(u)(5); and

(IV) meets such other requirements as the Secretary determines appropriate, taking into account the standards of care for home infusion therapy established by Medicare Advantage plans under part C and in the private sector.

(ii) A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services, or supplier to meet the requirements of this subparagraph.

(jjj) OPIOID USE DISORDER TREATMENT SERVICES; OPIOID TREATMENT PROGRAM.—

(1) OPIOID USE DISORDER TREATMENT SERVICES.—The term "opioid use disorder treatment services" means items and services that are furnished by an opioid treatment program for the treatment of opioid use disorder, including—

(A) opioid agonist and antagonist treatment medications (including oral, injected, or implanted versions) that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opioid use disorder;

(B) dispensing and administration of such medications, if applicable;

(C) substance use counseling by a professional to the extent authorized under State law to furnish such services;

(D) individual and group therapy with a physician or psychologist (or other mental health professional to the extent authorized under State law);

(E) toxicology testing, and

(F) other items and services that the Secretary determines are appropriate (but in no event to include meals or transportation).

(2) OPIOID TREATMENT PROGRAM.—The term "opioid treatment program" means an entity that is an opioid treatment program (as defined in section 8.2 of title 42 of the Code of Federal Regulations, or any successor regulation) that—

(A) is enrolled under section 1866(j);

(B) has in effect a certification by the Substance Abuse and Mental Health Services Administration for such a program;

(C) is accredited by an accrediting body approved by the Substance Abuse and Mental Health Services Administration; and

(D) meets such additional conditions as the Secretary may find necessary to ensure—

(i) the health and safety of individuals being furnished services under such program; and

(ii) the effective and efficient furnishing of such services.

(kkk) VISION SERVICES.—The term "vision services" means—

(1) routine eye examinations to determine the refractive state of the eyes, including procedures performed during the course of such examination; and

(2) contact lens fitting services;

furnished on or after January 1, 2022, by or under the direct supervision of an optometrist or ophthalmologist who is legally authorized to furnish such examinations, procedures, or fitting services (as applicable) under State law (or the State regulatory mechanism pro-

vided by State law) of the State in which the examinations, procedures, or fitting services are furnished.

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1861(ddd)(1)), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6),

(E) in the case of research conducted pursuant to section 1142, which is not reasonable and necessary to carry out the purposes of that section,

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which is not conducted by a facility described in section 1834(c)(1)(B), in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1861(nn), and, in the case of screening for glaucoma, which is performed more frequently than is provided under section 1861(uu),

(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d),

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation,

(J) in the case of a drug or biological specified in section 1847A(c)(6)(C) for which payment is made under part B that is furnished in a competitive area under section 1847B, that is not furnished by an entity under a contract under such section,

(K) in the case of an initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under part B,

(L) in the case of cardiovascular screening blood tests (as defined in section 1861(xx)(1)), which are performed more frequently than is covered under section 1861(xx)(2),

(M) in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3),

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1861(s)(2)(AA),

(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1861(ggg)), which are furnished in excess of the number of sessions covered under paragraph (4) of such section, **[**and**]**

(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section**[**;**]**, *and*

(Q) in the case of vision services (as defined in section 1861(kkk)) that are routine eye examinations and contact lens fitting services (as described in paragraph (1) or (2), respectively, of such section), which are furnished more frequently than once during a 2-year period;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in section 1861(aa)(1), in the case of Federally qualified health center services, as defined in section 1861(aa)(3), in the case of services for which payment may be made under section 1880(e), and in such other cases as the Secretary may specify;

(4) which are not provided within the United States (except for inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished);

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations *(other than such an examination that is a vision service that is covered under section 1861(s)(2)(II))* for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes *(other than such a procedure that is a vision service that is covered under section 1861(s)(2)(II))*, hearing aids or examinations therefor, or immu-

nizations (except as otherwise allowed under section 1861(s)(10) and subparagraph (B), (F), (G), (H), (K), or (P) of paragraph (1));

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1861(s)(12);

(9) where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C));

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or critical access hospital by an entity other than the hospital or critical access hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or critical access hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate quality improvement organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies;

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997;

(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary;

(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1861(s)(2)(D), which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility;

(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b);

(20) in the case of outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) (or under such sentence through the operation of subsection (g) or (ll)(2) of section 1861) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency;

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary;

(23) which are the technical component of advanced diagnostic imaging services described in section 1834(e)(1)(B) for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier (as defined in section 1861(d)), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1834(e)(2)(B);

(24) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services; or

(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B). In making a national coverage determination (as defined in paragraph (1)(B) of section 1869(f)) the Secretary shall ensure consistent with subsection (l) that the public is afforded notice and opportunity to comment prior to implementation by the Secretary of the determination; meetings of advisory committees with respect to the determination are made on the record; in making the determination, the Secretary has considered applicable information (including clinical experience and medical, technical, and scientific evidence) with respect to the subject matter of the determination; and in the determination, provide a clear statement of the basis for the determination (including responses to comments received from the public), the assumptions underlying that basis, and make available to the public the data (other than proprietary data) considered in making the determination.

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) WORKING AGED UNDER GROUP HEALTH PLANS.—

(i) IN GENERAL.—A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226(a), and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) EXCLUSION OF GROUP HEALTH PLAN OF A SMALL EMPLOYER.—Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) EXCEPTION FOR SMALL EMPLOYERS IN MULTIEMPLOYER OR MULTIPLE EMPLOYER GROUP HEALTH PLANS.—Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or

(without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

(v) GROUP HEALTH PLAN DEFINED.—In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code

(B) DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226(b).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

(iii) LARGE GROUP HEALTH PLAN DEFINED.—In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before the date of enactment of the Balanced Budget Act of 1997 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18- month" for "12-

month" each place it appears. Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) TREATMENT OF CERTAIN MEMBERS OF RELIGIOUS ORDERS.—In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) GENERAL PROVISIONS.—For purposes of this subsection:

(i) AGGREGATION RULES.—

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) CURRENT EMPLOYMENT STATUS DEFINED.—An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) TREATMENT OF SELF-EMPLOYED PERSONS AS EMPLOYERS.—The term "employer" includes a self-employed person.

(F) LIMITATION ON BENEFICIARY LIABILITY.—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) MEDICARE SECONDARY PAYER.—

(A) IN GENERAL.—Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In the subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) CONDITIONAL PAYMENT.—

(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) REPAYMENT REQUIRED.—Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) ACTION BY UNITED STATES.—In order to recover payment made under this title for an item or service, the United States may bring an action against any or

all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) SUBROGATION RIGHTS.—The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) WAIVER OF RIGHTS.—The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

(vi) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) USE OF WEBSITE TO DETERMINE FINAL CONDITIONAL REIMBURSEMENT AMOUNT.—

(I) NOTICE TO SECRETARY OF EXPECTED DATE OF A SETTLEMENT, JUDGMENT, ETC.—In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as de-

fined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) SECRETARIAL PROVIDING ACCESS TO CLAIMS INFORMATION THROUGH A WEBSITE.—The Secretary shall maintain and make available to individuals to whom items and services are furnished under this title (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this title relating to a potential settlement, judgment, award, or other payment.

(III) USE OF TIMELY WEB DOWNLOAD AS BASIS FOR FINAL CONDITIONAL AMOUNT.—If an individual (or other claimant or applicable plan with the con-

sent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) RESOLUTION OF DISCREPANCIES.—If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) PROTECTED PERIOD.—In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65

days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) EFFECTIVE DATE.—The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after the date of the enactment of this clause.

(VII) WEBSITE INCLUDING SUCCESSOR TECHNOLOGY.—In this clause, the term "website" includes any successor technology.

(viii) RIGHT OF APPEAL FOR SECONDARY PAYER DETERMINATIONS RELATING TO LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this title for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii), under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination

(C) TREATMENT OF QUESTIONNAIRES.—The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) ENFORCEMENT.—

(A) PRIVATE CAUSE OF ACTION.—There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) REFERENCE TO EXCISE TAX WITH RESPECT TO NONCONFORMING GROUP HEALTH PLANS.—For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) PROHIBITION OF FINANCIAL INCENTIVES NOT TO ENROLL IN A GROUP HEALTH PLAN OR A LARGE GROUP HEALTH PLAN.—It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this title not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(4) COORDINATION OF BENEFITS.—Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title (without regard to deductibles and coinsurance under this title) for the remainder of such charge, but—

(A) payment under this title may not exceed an amount which would be payable under this title for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this title, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this title on the basis of reasonable cost (or other cost-related basis) or under section 1886, the amount which would be payable under this title on such basis, and

(ii) in the case of an item or service for which payment is authorized under this title on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title),

whichever is greater.

(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

(A) REQUESTING MATCHING INFORMATION.—

(i) COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall, not less often that annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) ADMINISTRATOR.—The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Ad-

ministrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS.—In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) CONTACTING EMPLOYERS.—

(i) IN GENERAL.—With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) EMPLOYER RESPONSE.—Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provision of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(D) OBTAINING INFORMATION FROM BENEFICIARIES.—Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(E) END DATE.—The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) SCREENING REQUIREMENTS FOR PROVIDERS AND SUPPLIERS.—

(A) IN GENERAL.—Notwithstanding any other provision of this title, no payment may be made for any item or service furnished under part B unless the entity furnishing

such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) PENALTIES.—An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS.—

(A) REQUIREMENT.—On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been—

(I) a primary plan to the program under this title; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) ENFORCEMENT.—

(i) IN GENERAL.—An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

(C) SHARING OF INFORMATION.—Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—

(A) REQUIREMENT.—On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) REQUIRED INFORMATION.—The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after the date of enactment of this sentence, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House

of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) TIMING.—Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) CLAIMANT.—For purposes of subparagraph (A), the term "claimant" includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) ENFORCEMENT.—

(i) IN GENERAL.—An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) APPLICABLE PLAN.—In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) SHARING OF INFORMATION.—The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) REGULATIONS.—Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a bene-

ficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) EXCEPTION.—

(A) IN GENERAL.—Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) ANNUAL COMPUTATION OF THRESHOLD.—

(i) IN GENERAL.—Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) PUBLICATION.—The Secretary shall include, as part of such publication for a year—

(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) EXCLUSION OF ONGOING EXPENSES.—For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this title.

(D) REPORT TO CONGRESS.—Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

(i) calculate the threshold amount by using the methodology applicable to certain liability claims described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each threshold amount and the amount of estimated savings under this title achieved by the Secretary implementing each such threshold.

(c) No payment may be made under part B for any expenses incurred for—

(1) a drug product—

(A) which is described in section 107(c)(3) of the Drug Amendments of 1962,

(B) which may be dispensed only upon prescription,

(C) for which the Secretary has issued a notice of an opportunity for a hearing under subsection (e) of section 505 of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug product under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling, and

(D) for which the Secretary has not determined there is a compelling justification for its medical need; and

(2) any other drug product—

(A) which is identical, related, or similar (as determined in accordance with section 310.6 of title 21 of the Code of Federal Regulations) to a drug product described in paragraph (1), and

(B) for which the Secretary has not determined there is a compelling justification for its medical need,

until such time as the Secretary withdraws such proposed order.

(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867

to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.

(e)(1) No payment may be made under this title with respect to any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2) from participation in the program under this title; or

(B) at the medical direction or on the prescription of a physician during the period when he is excluded pursuant to section 1128, 1128A, 1156 or 1842(j)(2) from participation in the program under this title and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(2) Where an individual eligible for benefits under this title submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this title, pursuant to section 1128, 1128A, 1156, 1160 (as in effect on September 2, 1982), 1842(j)(2), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or l866, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this title, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.

(f) The Secretary shall establish utilization guidelines for the determination of whether or not payment may be made, consistent with paragraph (1)(A) of subsection (a), under part A or part B for expenses incurred with respect to the provision of home health services, and shall provide for the implementation of such guidelines through a process of selective postpayment coverage review by intermediaries or otherwise.

(g) The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a), and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this title, enter into con-

tracts with quality improvement organizations pursuant to part B of title XI of this Act.

(h)(1) The Secretary—

(A) shall waive the application of subsection (a)(22) in cases in which—

(i) there is no method available for the submission of claims in an electronic form; or

(ii) the entity submitting the claim is a small provider of services or supplier; and

(B) may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

(2) For purposes of this subsection, the term "small provider of services or supplier" means—

(A) a provider of services with fewer than 25 full-time equivalent employees; or

(B) a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.

(i) In order to supplement the activities of the Medicare Payment Advisory Commission under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

(j)(1) Any advisory committee appointed to advise the Secretary on matters relating to the interpretation, application, or implementation of subsection (a)(1) shall assure the full participation of a nonvoting member in the deliberations of the advisory committee, and shall provide such nonvoting member access to all information and data made available to voting members of the advisory committee, other than information that—

(A) is exempt from disclosure pursuant to subsection (a) of section 552 of title 5, United States Code, by reason of subsection (b)(4) of such section (relating to trade secrets); or

(B) the Secretary determines would present a conflict of interest relating to such nonvoting member.

(2) If an advisory committee described in paragraph (1) organizes into panels of experts according to types of items or services considered by the advisory committee, any such panel of experts may report any recommendation with respect to such items or services directly to the Secretary without the prior approval of the advisory committee or an executive committee thereof.

(k)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary cov-

erage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

(l) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) FACTORS AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—

(A) PERIOD FOR PROPOSED DECISION.—Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

(B) 30-DAY PERIOD FOR PUBLIC COMMENT.—Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

(C) 60-DAY PERIOD FOR FINAL DECISION.—Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

(i) make a final decision on the request;

(ii) include in such final decision summaries of the public comments received and responses to such comments;

(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

(5) LOCAL COVERAGE DETERMINATION PROCESS.—

(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

(D) LOCAL COVERAGE DETERMINATIONS.—The Secretary shall require each Medicare administrative contractor that develops a local coverage determination to make available on the Internet website of such contractor and on the Medicare Internet website, at least 45 days before the effective date of such determination, the following information:

(i) Such determination in its entirety.

(ii) Where and when the proposed determination was first made public.

(iii) Hyperlinks to the proposed determination and a response to comments submitted to the contractor with respect to such proposed determination.

(iv) A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence.

(v) An explanation of the rationale that supports such determination.

(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection—

(A) NATIONAL COVERAGE DETERMINATION.—The term "national coverage determination" means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title.

(B) LOCAL COVERAGE DETERMINATION.—The term "local coverage determination" has the meaning given that in section 1869(f)(2)(B).

(m) COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DEVICES.—

(1) IN GENERAL.—In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

(2) CATEGORY A CLINICAL TRIAL.—For purposes of paragraph (1), a "category A clinical trial" means a trial of a medical device if—

(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.

(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).

(o) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

(3) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection, section 1860D–12(b)(7) (including as applied pursuant to section 1857(f)(3)(D)), and section 1903(i)(2)(C).

(4) CREDIBLE ALLEGATION OF FRAUD.—In carrying out this subsection, section 1860D–12(b)(7) (including as applied pursuant to section 1857(f)(3)(D)), and section 1903(i)(2)(C), a fraud hotline tip (as defined by the Secretary) without further evidence shall not be treated as sufficient evidence for a credible allegation of fraud.

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VII. ADDITIONAL VIEWS

H.R. 4665 expands the fee-for-service Medicare entitlement. Yet, this critical program is already suffering from funding shortfalls and waves of baby boomers are continue to enroll. The Hospital Insurance (HI) Trust Fund that funds Part A of Medicare is expected to be insolvent by 2026, less than seven years from today. That means benefits will have to be cut, taxes will have to be raised, or some combination of both.

The Medicare fee-for-service system, as operated today, is simply unsustainable. For years, Washington has punted on structural changes to these entitlement programs. The result has been a slowly crumbling social safety net that is failing health care providers and, most importantly, our seniors who rely on them most.

Either we tackle these problems now or they will tackle us.

Fortunately, there is a bright spot: Medicare Advantage, private plans competing for seniors' business, is delivering lower costs and providing more generous benefits for seniors than the antiquated fee-for-service Medicare.

Premiums for the 24 million seniors expected to enroll in 2020 will be 23% lower than in 2018, which is the lowest monthly premiums have been in 13 years. Seniors enrolled in Medicare Advantage plans have seen billions of dollars in savings for their health care costs.

Privately administered Medicare Advantage plans already provide supplemental hearing, vision and dental benefits to seniors. In fact, nearly nine out of ten total Medicare Advantage plans offer some form of dental, vision, and hearing coverage.

Now, we know "Medicare for All" would eliminate these plans that seniors like. And Republicans are steadfast in our opposition to that radical scheme.

Committee Republicans have serious reservations about expanding Medicare fee-for-service without fixing its fundamental flaws for those in or near retirement. The majority rushed these bills through a markup without CBO scores. Despite this lack of analysis, Republicans on the Committee were willing to advance the process on these bills until such a time when we can get a complete CBO analysis and are hopeful we can come to an agreement on bipartisan pay-fors that do not include H.R. 3's government price setting.

Should Congressional Democrats use the price setting cuts to spending in their drug bill as a pay-for for these Medicare fee-for-service expansion, Republicans will stand fast in opposition.

KEVIN BRADY,
Republican Leader, Committee on Ways and Means.

DEVIN NUNES,
Republican Leader, Health Subcommittee, Committee on Ways and Means.

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