118TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 118–765
Part 1

PROVIDERS AND PAYERS COMPETE ACT

NOVEMBER 22, 2024.—Ordered to be printed

Mrs. RODGERS of Washington, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 3284]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3284) to require the Secretary of Health and Human Services to submit an annual report on the impact of certain Medicare regulations on provider and payer consolidation, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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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 "Providers and Payers COMPETE Act".

SEC. 2. ANNUAL REPORT ON THE IMPACT OF CERTAIN MEDICARE REGULATIONS ON PROVIDER AND PAYER CONSOLIDATION; PUBLIC COMMENT ON PROVIDER AND PAYER CONSOLIDATION FOR CERTAIN PROPOSED RULES.

(a) ANNUAL REPORT.—Not later than December 31, 2026, and annually thereafter, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall submit to Congress a report on the impact in the aggregate on provider and payer consolidation with respect to regulations and rules for parts B, C, and D of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) implemented in the calendar year immediately prior to such report. Such report shall include regulations and rules that—

(1) implement a change to an applicable payment system, a rate schedule, or another payment system under parts B, C, or D of such title; or

(2) result in a significant rule effecting provider or payer consolidation.

(b) PUBLIC COMMENT ON IMPACT TO PROVIDER AND PAYER CONSOLIDATION.—Beginning for 2025, as part of any notice and comment rulemaking process that will result in a significant rule effecting provider or payer consolidation with respect to a proposed rule for parts B, C, and D of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), the Secretary shall seek public comment on the projected impact of such proposed rule on provider and payer consolidation in the aggregate.

(c) DEFINITIONS.—In this section:

(1) PROVIDER AND PAYER CONSOLIDATION.—The term "provider and payer consolidation" includes the vertical or horizontal integration among providers of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)), suppliers (as defined in subsection (d) of such section), accountable care organizations under section 1899 of the Social Security Act (42 U.S.C. 1395jjj), Medicare Advantage organizations, PDP sponsors, pharmacy benefit managers, pharmacies, and integrated delivery systems.

(2) APPLICABLE PAYMENT SYSTEM.—The term "applicable payment system" includes—

(A) with respect to outpatient hospital services, the prospective payment system for covered OPD services established under section 1833(t) of such Act (42 U.S.C. 1395(l)); and

(B) with respect to physicians' services, the physician fee schedules established under section 1848 of such Act (42 U.S.C. 1395w–4).

SEC. 3. CONSIDERATION OF EFFECTS ON PROVIDER AND PAYER CONSOLIDATION WITH RESPECT TO CMI MODELS.

(a) IN GENERAL.—Section 1115A(b)(4)(A) of the Social Security Act (42 U.S.C. 1315a(b)(4)(A)) is amended—

(1) in clause (i), by striking at the end "and";

(2) in clause (ii), by striking the period at the end and inserting "; and"; and

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

"(iii) the extent to which, and how, the model has affected and could affect provider and payer consolidation, which includes the vertical or horizontal integration among providers of services (as defined in subsection (u) of section 1861), suppliers (as defined in subsection (d) of such section), and accountable care organizations under section 1899.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to models tested on or after January 1, 2025.

PURPOSE AND SUMMARY

The bill would require that the Secretary of Health and Human Services submit an annual report on the impact of Medicare regulations on provider and payer consolidation.

BACKGROUND AND NEED FOR LEGISLATION

Market consolidation has been linked to less price competition for different providers and payers. Horizontal consolidation, including mergers between providers in the same market, and vertical consolidation among providers, such as hospitals acquiring physician practices, has been shown to lead to higher costs for patients. The share of metropolitan statistical areas analyzed by the Congressional Budget Office (CBO) as being concentrated or highly concentrated increased from 63 percent to 70 percent from 2010–2017. This bill would require an annual report from the Department of

Health and Human Services (HHS) to look at the impact of Medicare regulations on consolidation, and would require HHS to evaluate the extent to which the Centers for Medicare and Medicaid Services' (CMS) Innovation Center models impact provider and payer consolidation.

COMMITTEE ACTION

On March 28, 2023, the Subcommittee on Health held a hearing on matters related to the cost of health care and price transparency. The title of the hearing was "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care." The Subcommittee received testimony from:

- Chris Severn, Co-Founder & Chief Executive Officer, Turquoise Health;
- Matthew Forge, Chief Executive Officer, Pullman Regional Hospital;
- Marilyn Bartlett, Senior Policy Fellow, National Association of State Health Policy;
- Sophia Tripoli, Director of Health Care Innovation, Families USA; and
- Benedic Ippolito, Senior Fellow in Economic Policy Studies, American Enterprise Institute.

On April 26, 2023, the Subcommittee on Health held a hearing on several pieces of legislation, including a discussion draft titled "To amend titles XI and XVIII of the Social Security Act to require each outpatient department of a provider to include a unique identification number on claims for services, and to require hospitals with an outpatient department of a provider to submit to the Centers for Medicare & Medicaid Services an attestation with respect to each such outpatient department." The title of the hearing was "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The Subcommittee received testimony from:

- Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services;
- Ashley Thompson, Senior Vice President, Public Policy Analysis and Development, American Hospital Association;
- Kristin Bass, Chief Policy and External Affairs Officer, Pharmaceutical Care Management Association;
- Brian Connell, Executive Director, Federal Affairs, The Leukemia and Lymphoma Society;
- Sean Cavanaugh, Chief Policy Officer, Aledade, Inc.;
- Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council; and
- Loren Adler, Fellow and Associate Director, USC Brookings Initiative for Health Policy, Economic Studies Program, Brookings Institution.

H.R. 3284, the "Providers and Payers COMPETE Act" was introduced on May 15, 2023, by Representative Michael C. Burgess (R–TX) and Representative Debbie Dingell (D–MI). H.R. 3284 is based on the discussion draft that the Subcommittee on Health reviewed at its hearing on April 26, 2023.

On May 17, 2023, the Subcommittee on Health met in open markup session and forwarded H.R. 3284, without amendment, to the full Committee by a record vote of 27 yeas and 0 nays.

On May 24, 2023, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 3284, as amended, favorably reported to the House by a record vote of 49 yeas and 0 nays.

COMMITTEE VOTES

Clause 3(b) of rule XIII requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following reflects the record votes taken during the Committee consideration:

COMMITTEE ON ENERGY AND COMMERCE
118TH CONGRESS
ROLL CALL VOTE # 4

BILL: H.R. 3284, the "Providers and Payers COMPETE Act"

AMENDMENT: A motion by Rep. Rodgers to order H.R. 3284 favorably reported to the House, as amended (Final Passage)

DISPOSITION: **AGREED TO,** by a roll call vote of 49 Yeas and 0 Nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Rep. Burgess	X			Rep. Pallone	X		
Rep. Latta	X			Rep. Eshoo	X		
Rep. Guthrie	X			Rep. DeGette	X		
Rep. Griffith	X			Rep. Schakowsky	X		
Rep. Bilirakis	X			Rep. Matsui	X		
Rep. Johnson	X			Rep. Castor	X		
Rep. Bucshon	X			Rep. Sarbanes	X		
Rep. Hudson	X			Rep. Tonko	X		
Rep. Walberg	X			Rep. Clarke	X		
Rep. Carter	X			Rep. Cárdenas	X		
Rep. Duncan	X			Rep. Ruiz	X		
Rep. Palmer	X			Rep. Peters	X		
Rep. Dunn	X			Rep. Dingell	X		
Rep. Curtis				Rep. Veasey	X		
Rep. Lesko	X			Rep. Kuster	X		
Rep. Pence	X			Rep. Kelly	X		
Rep. Crenshaw				Rep. Barragán	X		
Rep. Joyce	X			Rep. Blunt Rochester	X		
Rep. Armstrong	X			Rep. Soto	X		
Rep. Weber	X			Rep. Craig	X		
Rep. Allen	X			Rep. Schrier	X		
Rep. Balderson	X			Rep. Trahan	X		
Rep. Fulcher	X			Rep. Fletcher	X		
Rep. Pfluger	X						
Rep. Harshbarger	X						
Rep. Miller-Meeks	X						
Rep. Cammack	X						
Rep. Obernolte							
Rep. Rodgers	X						

OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII, the Committee held hearings and made findings that are reflected in this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to clause 3(c)(2) of rule XIII, the Committee finds that H.R. 3284 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII, at the time this report was filed, the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974 was not available.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to have the Secretary of Health and Human Services submit a report on the impact of Medicare regulations on provider and payer consolidation.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 3284 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

RELATED COMMITTEE AND SUBCOMMITTEE HEARINGS

Pursuant to clause 3(c)(6) of rule XIII, the following related hearings were used to develop or consider H.R. 3284:

- On March 28, 2023, the Subcommittee on Health held a hearing. The title of the hearing was "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care." The Subcommittee received testimony from:
  - Chris Severn, Co-Founder & Chief Executive Officer, Turquoise Health;
  - Matthew Forge, Chief Executive Officer, Pullman Regional Hospital;
  - Marilyn Bartlett, Senior Policy Fellow, National Association of State Health Policy;
  - Sophia Tripoli, Director of Health Care Innovation, Families USA; and
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- On April 26, 2023, the Subcommittee on Health held a hearing. The title of the hearing was "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The Subcommittee received testimony from:
  - Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services;
  - Ashley Thompson, Senior Vice President, Public Policy Analysis and Development, American Hospital Association;
  - Kristin Bass, Chief Policy and External Affairs Officer, Pharmaceutical Care Management Association;
  - Brian Connell, Executive Director, Federal Affairs, The Leukemia and Lymphoma Society;
  - Sean Cavanaugh, Chief Policy Officer, Aledade, Inc.;
  - Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council; and
  - Loren Adler, Fellow and Associate Director, USC-Brookings Initiative for Health Policy, Economic Studies Program, Brookings Institution.

COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974. At the time this report was filed, the estimate was not available.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 3284 contains no earmarks, limited tax benefits, or limited tariff benefits.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 provides that the Act may be cited as the "Providers and Payers COMPETE Act."

Section 2. Annual report on the impact of certain medicare regulations on provider and payer consolidation; public comment on provider and payer consolidation for certain proposed rules

Section 2 requires that the Secretary of Health and Human Services (HHS) submit an annual report to Congress no later than De-

cember 31, 2026, and annually thereafter, on the aggregate impact that certain HHS rules under title XVIII of the Social Security have on provider and payer consolidation. Starting in 2025, the Secretary shall seek public comment on the projected impact that HHS rules will have on provider and payer consolidation as part of its notice and comment rulemaking process. The terms "provider and payer consolidation" and "applicable payment system" are also defined.

Section 3. Consideration of effects on provider and payer consolidation with respect to CMI models

Section 3 requires the Secretary to evaluate the extent to which, and how, a Center for Medicare and Medicaid Innovation (CMI) model has affected and could affect provider and payer consolidation. This requirement is effective for models tested on or after January 1, 2025.

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 italics, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

* * * * * * *

CENTER FOR MEDICARE AND MEDICAID INNOVATION

SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the "CMI") to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

(4) DEFINITIONS.—In this section:

(A) APPLICABLE INDIVIDUAL.—The term "applicable individual" means—

(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

(iii) an individual who meets the criteria of both clauses (i) and (ii).

(B) APPLICABLE TITLE.—The term "applicable title" means title XVIII, title XIX, or both.

(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.

(b) TESTING OF MODELS (PHASE I).—

(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

(2) SELECTION OF MODELS TO BE TESTED.—

(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title. The models selected under this subparagraph may include, but are not limited to, the models described in subparagraph (B).

(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

(I) An inability to perform 2 or more activities of daily living.

(II) Cognitive impairment, including dementia.

(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

(I) developing, documenting, and disseminating best practices and proven care methods;

(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

(I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and

(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note).

(xxi) Focusing primarily on physicians' services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

(xxii) Focusing on practices of 15 or fewer professionals.

(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services.

(xxv) Providing, for the adoption and use of certified EHR technology (as defined in section 1848(o)(4)) to improve the quality and coordination of care through the electronic documentation and exchange of health information, incentive payments to behavioral health providers (such as psychiatric hospitals (as defined in section 1861(f)), community mental health centers (as defined in section 1861(ff)(3)(B)), hospitals that participate in a State plan under title XIX or a waiver of such plan, treatment facilities that participate in such a State plan or such a waiver, mental health or substance use disorder providers that participate in such a State plan or such a waiver, clinical psychologists (as defined in section 1861(ii)), nurse practitioners (as defined in section 1861(aa)(5)) with respect to the provision of psychiatric services, and clinical social workers (as defined in section 1861(hh)(1))).

(xxvi) Supporting ways to familiarize individuals with the availability of coverage under part B of title XVIII for qualified psychologist services (as defined in section 1861(ii)).

(xxvii) Exploring ways to avoid unnecessary hospitalizations or emergency department visits for mental and behavioral health services (such as for treating depression) through use of a 24-hour, 7-day a week help line that may inform individuals about the availability of treatment options, including the availability of qualified psychologist services (as defined in section 1861(ii)).

(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

(iii) Whether the model provides for in-person contact with applicable individuals.

(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

(viii) Whether the model demonstrates effective linkage with other public sector payers, private sector payers, or statewide payment models.

(3) BUDGET NEUTRALITY.—

(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

(ii) reduce spending under the applicable title without reducing the quality of care; or

(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

(4) EVALUATION.—

(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; [and]

(ii) the changes in spending under the applicable titles by reason of the model[.]*; and*

(iii) the extent to which, and how, the model has affected and could affect provider and payer consolidation, which includes the vertical or horizontal integration among providers of services (as defined in subsection (u) of section 1861), suppliers (as defined in subsection (d) of such section), and accountable care organizations under section 1899.

(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

(C) MEASURE SELECTION.—To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).

(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under applicable title without reducing the quality of care; or

(B) improve the quality of patient care without increasing spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals.

In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

(d) IMPLEMENTATION.—

(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than sub-

sections (b)(1)(A) and (c)(5) of such section) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

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

(A) the selection of models for testing or expansion under this section;

(B) the selection of organizations, sites, or participants to test those models selected;

(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

(D) determinations regarding budget neutrality under subsection (b)(3);

(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

(f) FUNDING.—

(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection

(b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.

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