

PAYMENT FOR PHYSICIANS' SERVICES^[234]

SEC. 1848. [42 U.S.C. 1395w-4] (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^[235], 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) **INCENTIVE PAYMENT ADJUSTMENT.**—

(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) EXCEPTION 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 HER 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^[236], if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

(ii) APPLICABLE PERCENT.—Subject to clause (iii), for purposes of clause (i), the term “applicable percent” means—

(I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent);

(II) for 2016, 98 percent; and

(III) for 2017 and 2018^[237], 97 percent.

(iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2018^[238].—For 2018^[239], 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^[240].

(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 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.^[241]

(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.^{[242][243]}

(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^[244], 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^[245], 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) Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(C) DEFINITIONS.—For purposes of this paragraph:

(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms “eligible professional” and “covered professional services” have the meanings given such terms in subsection (k)(3).

(ii) 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.—^[246]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^[247], 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 subparagraph, 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^[248], dual-energy x-ray absorptiometry services (as described in paragraph (6)).

(C)^[249] ADJUSTMENT IN IMAGING UTILIZATION RATE.—With respect to fee schedules established for 2011 and subsequent years^[250], 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.^[251]

(D)^[252] 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^[253], 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 first 2 months of 2012^[254], 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,^[255] 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.^[256]

(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."^[257]

(9) SPECIAL RULE TO INCENTIVIZE TRANSITION FROM TRADITIONAL X-RAY IMAGING TO DIGITAL RADIOGRAPHY.
—^[258]

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

(B) PHASED-IN LIMITATION ON PAYMENT FOR COMPUTED RADIOGRAPHY IMAGING SERVICES. — In the case of an imaging service (including the imaging portion of a service) that is an X-ray taken using computed radiography technology —

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

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

(C) COMPUTED RADIOGRAPHY TECHNOLOGY DEFINED. — For purposes of this paragraph, the term 'computed radiography technology' means cassette-based imaging which utilizes an imaging plate to create the image involved.

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

(10) REDUCTION OF DISCOUNT IN PAYMENT FOR PROFESSIONAL COMPONENT OF MULTIPLE IMAGING SERVICES. —^[259] 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.

(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^[260].

(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)^[261], 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.**—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^[262].

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.— The following reduces 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 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)[263] 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^[264] subsection (b)(4)(C).

(IV) ~~Stricken.~~^[265]

(V) ~~Stricken.~~^[266]

(VI)[267] 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 payment reduction for therapy services (as described in subsection (b)(7)).

(VIII) REDUCED EXPENDITURES ATTRIBUTABLE TO APPLICATION OF QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—Effective for fee schedules established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1834(p).^[268]

(IX) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2017, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).^[269]

(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.^[270]

(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).^[271]

(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 service^[272]s based on the relative resources incorporating physician time and intensity required in furnishing the service.

(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^[273].

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^[274] for years before 2000 equal to the product of—

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

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

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

(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 percent of the number of work relative value units (determined for such year).

(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this 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^[275].

(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)^[276] 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)^[277].

(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.^[278]

(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).^[279]

(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2016 through 2018, ^[280]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^[281].

(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.^[282]

(3)^[283] 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 1999, 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.^[284]

(8) GLOBAL SURGICAL PACKAGES.^[285]—

(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^[286], multiplied by the update (established under paragraph (4) or a subsequent paragraph^[287]) for the year involved. There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 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.^[288]

(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)^[289] established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

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

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable growth rate and

of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

(2) **Stricken.**^[290]

(3) **UPDATE FOR 1999 AND 2000.**—

(A) **IN GENERAL.**—Unless otherwise provided by law, subject to subparagraph (D) and the budget–neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 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: $(1.03 + (\text{MEI percentage}/100)) - 1$; or

(ii) less than 100 times the following amount: $(0.93 + (\text{MEI percentage}/100)) - 1$,

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.**—^[291]

(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^[292] 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 each of 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) and 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) and (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) and (8)(B), and (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 REMAINING PORTION OF 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)[293] UPDATE 2012^[294].—

(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^[295], the update to the single conversion factor shall be zero percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2013^[296] AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2013^[297] and subsequent years as if subparagraph (A) had never applied.

(14)[298] 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.—^[299]

(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.
[300]

(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. ^[301]

(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. ^[302]

(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 2019The update to the single conversion factor established in paragraph (1)(C) for 2016 and each subsequent year through 2019 shall be 0.5 percent.

(19) UPDATE FOR 2020 THROUGH 2025The 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^[303].—

(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 1/4 of the difference between the relative value of physicians' work effort in each of the different fee schedule areas and the national average of such work effort.

(B) CLASS-SPECIFIC GEOGRAPHIC COST-OF-PRACTICE INDICES.—The Secretary may establish more than one index under subparagraph (A)(i) in the case of classes of physicians' services, if, because of differences in the mix of goods and services comprising practice expenses for the different classes of services, the application of a single index under such clause to different classes of such services would be substantially inequitable.

(C) PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.—The Secretary, not less often than every 3 years, shall, in consultation with appropriate representatives of physicians, review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the date of the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be 1/2 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, 2018^[304], 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)^[305] 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^[306]

(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 1/2 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 1/2 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 than 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.^[307]

(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^[308] 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^[309] 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 fiscal year 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 fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B) or (d)(4)(B), as the case may be, minus 1 and multiplied by 100.

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

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

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

(C) FOR 2003 AND SUCCEEDING YEARS.—For purposes of such calculations for a year after 2002

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

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

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

(4) DEFINITIONS.— In this subsection:

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

(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term "Medicare+Choice plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this 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 assignment-related basis. No person is liable for payment of any amounts billed for such a service in violation of the previous sentence. If a person knowingly and willfully bills for physicians' services in violation of the first sentence, the Secretary may apply sanctions against the person in accordance with section 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 furnishing 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,^[310]

(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).^[311]

(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), ^[312]the term "fee schedule area" means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.^[313]

(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 subparagraphs (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), (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 subsections (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 and 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(II)(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 reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

(8) IMPLEMENTATION.—The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare and 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.^[314]

(I) PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

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

(2) FUNDING.—

(A) AMOUNT AVAILABLE.—

(i) IN GENERAL.—Subject to clause (ii), there shall be available to the Fund the following amounts:

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

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

(ii) LIMITATIONS ON EXPENDITURES.—

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

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

(B) TIMELY OBLIGATION OF ALL AVAILABLE FUNDS FOR SERVICES.—The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount available for expenditures, after application of subparagraph (A)(ii), during—

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

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

(C) PAYMENT FROM TRUST FUND.—The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 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 and 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;

(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.

(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.

(2)[315] 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);

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

(3) SATISFACTORY REPORTING AND SUCCESSFUL ELECTRONIC PRESCRIBER DESCRIBED.—

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

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

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

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

(B) SUCCESSFUL ELECTRONIC PRESCRIBER.—

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

(ii) REQUIREMENT FOR SUBMITTING DATA ON ELECTRONIC PRESCRIBING QUALITY MEASURES.—The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such

professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

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

(iv) USE OF PART D DATA.—Notwithstanding sections 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^[316] 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)^[317] 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)^[318] 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)^[319] 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.

(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)[320] 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 2008, the Secretary shall presume that if an eligible professional submits data for a measure, such measure is applicable to such professional.

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

(iii) DENIAL OF PAYMENT AUTHORITY.—If the Secretary determines that an eligible professional (or, in the case of a group practice under paragraph (3)(C), the group practice) has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the incentive payment under this subsection. If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).

(E) LIMITATIONS ON REVIEW.—Except as provided in subparagraph (I), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise 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^[321] the Secretary shall establish and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish^[322] alternative criteria for satisfactorily reporting under this subsection and alternative

reporting periods under paragraph (6)(C) for reporting groups of measures under paragraph (2)(B) of subsection (k)(2)(B) and for reporting using the method specified in subsection (k)(4).

(G) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

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

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

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

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

(6) DEFINITIONS.—For purposes of this subsection:

(A) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms “eligible professional” and “covered professional services” have the meanings given such terms in subsection (k)(3).

(B) PHYSICIAN REPORTING SYSTEM.—The term “physician reporting system” means the system established under subsection (k).

(C) REPORTING PERIOD.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term “reporting period” means—

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

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

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

(iii) REFERENCE.—Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) 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)[323] 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)[324] 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));
 - (bb) an alternative form and manner determined appropriate by the Secretary.
 - (ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—
 - (I) participates in such a Maintenance of Certification program for a year; and
 - (II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.
 - (iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—
 - (I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii) (which may be in the form of a structural measure);
 - (II) if requested by the Secretary, on the survey of patient experience with care (as described in subparagraph (C)(ii)(II)); and
 - (III) as the Secretary may require, on the methods, measures, and data used under the Maintenance of Certification Program and the qualified Maintenance of Certification Program practice assessment.
- (C) DEFINITIONS.—For purposes of this paragraph:
- (i) The term “Maintenance of Certification Program” means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and selfassessment^[325] 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.^[326]
- (9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection
- (A) for purposes of subsection (q); and
 - (B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.^[327]

(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”) under which 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. 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.

(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^[328].

(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.”^[329]

(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, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(D) PAYMENT.—

(i) FORM OF PAYMENT.—The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

(ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.—In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

(iii) COORDINATION WITH MEDICAID.—The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this 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^[330] eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year^[331]) 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.^[332]

(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and subsection (q)(5)(B)(ii)(II)^[333] 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 by requiring more stringent measures of meaningful use selected under this paragraph.

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

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

(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

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

- (I) an attestation;
- (II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);
- (III) a survey response;
- (IV) reporting under subparagraph (A)(iii); and
- (V) other means specified by the Secretary.

(ii) USE OF PART D DATA.—Notwithstanding sections 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).^[334]

(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 modifier shall be separate from the geographic adjustment factors established under subsection (e).

(2) QUALITY.—

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

(B) MEASURES.—

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

(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 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).^[335]

(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).^[336]

(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.^[337]

(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 Secretary 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 items and services 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 individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part 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 appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

(iii) **CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.** —For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

(II) The subcategory of population management, such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

(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 methodology established under subparagraph (A), the Secretary shall —

(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE. —

(i) RULE FOR CERTIFICATION. — A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

(ii) APM PARTICIPATION. — Participation by a MIPS eligible professional in an alternative payment model (as defined in section 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), shall take into account the improvement of the professional; and

(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT. — Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

(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 2 YEARS. — For the first and second 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 (I)(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 2 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 the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES. — Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY. — Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION. — In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable

under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES. — Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0) —

(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

(G) RESOURCE USE. — Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS. — In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES. —

(i) IN GENERAL. — In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A) —

(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP. — The Secretary shall, in accordance with the requirements under clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

(iii) REQUIREMENTS. — The requirements for the process under clause (ii) shall —

(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

- (III) provide that a virtual group be a combination of tax identification numbers;
- (IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and
- (V) include such other requirements as the Secretary determines appropriate.

(6)MIPS PAYMENTS. —

(A) MIPS ADJUSTMENT FACTOR. — Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined —

- (i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;
- (ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that —

(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

- (iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

- (iv) in a manner such that —

(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than $\frac{1}{4}$ 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. 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, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, 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 2 YEARS.** — With respect to each of the first two 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.

(E) **APPLICATION OF MIPS ADJUSTMENT FACTORS.** — In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2019), the amount otherwise paid under this part with respect to such items and 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 items and services 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.^[338]

(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 $\frac{1}{2}$ 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.

(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 themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) considers themselves 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.^[339]

(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)(2)(C).

(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.^[340]

[234] See Vol. II, P.L. 106-554, §1(a)(6)[542], with respect to treatment of certain physician pathology services under Medicare.

See Vol. II, P.L. 108-173, §303(a)(2), with respect to the treatment of other services currently in non-physician work pool, and §303(a)(3), with respect to payment for multiple chemotherapy agents furnished on a single day through the push technique; §303(a)(5), with respect to MEDPAC review and reports and secretarial response.

See Vol. II, P.L. 109-432, §101(e), with respect to the transfer of funds for implementation of the amendments made by P.L. 109-432, Division B, Title I, §101(a), (b) and (d), which added §1848(d)(7), (k) and (l), respectively.

See Vol. II, P.L. 110-275, §131(b)(4)(B), with respect to billing for audiology services, and §138, with respect to an adjustment for Medicare mental health services.

See Vol. II, P.L. 112-96, §3003(b), with respect to a study by the Secretary of Health and Human Services on options for bundled or episode-based payment, and §3003(c), with respect to a GAO study of private payer initiatives.

[235] See Vol. II, P.L. 106-33, §13515(b).

[236] P.L. 114-10, §101(b)(1). Struck "2015 or any subsequent payment year" and inserted "each of 2015 through 2018". Effective April 16, 2015

[237] P.L. 114-10, §101(b)(1). Struck "each subsequent year" and inserted "2018". Effective April 16, 2015

[238] P.L. 114-10, §101(b)(1). Struck "and subsequent years"

[239] P.L. 114-10, §101(b)(1). Struck "and each subsequent year"

[240] P.L. 114-10, §101(b)(1). Struck ", but in no case shall the applicable percent be less than 95 percent"

[241] P.L.114-255, §4002(b)(1)(A); inserted "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." after the first sentence. Effective December 10, 2016.

[242] P.L.114-255, §16003(1); In header — struck "hospital-based eligible professionals" and inserted "hospital-based and ambulatory surgical center-based eligible professionals"; restructured text to create clause (i). Effective December 10, 2016.

* P.L.114-255, §16003(2); Inserted clauses (ii), (iii), and (iv). Effective December 10, 2016.

[244] P.L. 114-10, §101(b)(2). Struck "2015 or any subsequent year" and inserted "each of 2015 through 2018".

[245] P.L. 114-10, §101(b)(2). Struck "and each subsequent year" and inserted "2017, and 2018".

[246] P.L. 114-10 §523(b), inserted paragraph (9); effective April 16, 2015.

[247] See Vol. II, P.L. 100-203, §4048(b).

[248] P.L. 112-78, §309(1)(A), struck out "and 2011" and inserted ", 2011, and the first 2 months of 2012", effective December 23, 2011.

[249] See Vol. II, P.L.111-148, §3135(c), with respect to an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services relating to the cumulative expenditure reductions attributable to the adjustments under the amendments by P.L.111-148, §3135(a) and (b).

[250] P.L. 112-240, §635(1)(A), struck out "and subsequent years" and inserted ", 2012 and 2013", effective January 2, 2013.

[251] P.L. 112-240, §635(1)(B), added this new sentence, effective January 2, 2013.

[252] See Vol. II, P.L.111-148, §3135(c), with respect to an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services relating to the cumulative expenditure reductions attributable to the adjustments under the amendments by P.L.111-148, §3135(a) and (b).

[253] P.L. 112-78, §309(1)(B)(i), struck out "and 2011" and inserted ", 2011, and the first 2 months of 2012", effective December 23, 2011.

[254] P.L. 112-78, §309(1)(B)(ii), struck out "and 2011" and inserted ", 2011, and the first 2 months of 2012", effective December 23, 2011.

[255] P.L. 112-240, §633(a)(1), struck out "2011," and inserted "2011, and before April 1, 2013," effective January 2, 2013.

[256] P.L. 112-240, §633(a)(2), added this new sentence, effective January 2, 2013.

[257] P.L. 114-10, §103(a) Added paragraph (8) Effective April 16, 2015.

[258] P.L. 114-113, §502(a)(1)(A) Inserted paragraph (9) Effective December 18, 2015.

[259] P.L. 114-113, §502(a)(2)(A) Inserted paragraph (10) Effective December 18, 2015.

- [260] See Vol. II, P.L. 103-66, §13515(b).
- [261] P.L. 113-93, §220(e)(2)(A), added "and paragraph (7)". Effective April 1, 2014.
- [262] P.L. 112-78, §309(2), struck out "or 2011" and inserted ", 2011, or the first 2 months of 2012", effective December 23, 2011.
- [263] See Vol. II, P.L. 111-148, §3135(c), with respect to an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services relating to the cumulative expenditure reductions attributable to the adjustments under the amendments by P.L. 111-148, §3135(a) and (b).
- [264] P.L. 112-240, §635(2), struck out "change in the utilization rate applicable to 2011, as described in" and inserted "changes in the utilization rate applicable to 2011 and 2014, as described in the first and second sentence, respectively of", effective January 2, 2013.
- [265] P.L. 111-152, §1107(2), struck out subclause (IV) [as added by P.L. 111-148, §3135(a)(2)], effective March 30, 2010. For subclause (IV) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 111-152.
- [266] P.L. 111-152, §1107(2), struck out subclause (V) [as added by P.L. 111-148, §3135(a)(2)], effective March 30, 2010. For subclause (V) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 111-152.
- [267] See Vol. II, P.L. 111-148, §3135(c), with respect to an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services relating to the cumulative expenditure reductions attributable to the adjustments under the amendments by P.L. 111-148, §3135(a) and (b).
- [268] P.L. 113-93, §218(a)(2)(B), added subclause (VIII). Effective April 1, 2014.
- [269] P.L. 113-93, §220(d)(2), added as subclause (VIII). Effective April 1, 2014.
- P.L. 113-295, §202(1)(A-B) redesignated to subclause (IX). Effective December 19, 2014.
- [270] P.L. 114-113, §502(a)(1)(B) inserted subclause (X). Effective December 18, 2015.
- [271] P.L. 114-113, §502(a)(2)(B) inserted subclause (XI). Effective December 18, 2015.
- [272] P.L. 113-93, §220(f)(1), added "or group of services". Effective April 1, 2014.
- [273] P.L. 113-93, §220(f)(2), added "or group of services". Effective April 1, 2014.
- [274] P.L. 113-93, §220(f)(1), added "or group of services". Effective April 1, 2014.
- [275] P.L. 113-93, §220(c), struck clause (ii), and inserted new clause (ii). Effective April 1, 2014.
- [276] P.L. 113-93, §220(e)(2)(B)(i), added "and paragraph (7)". Effective April 1, 2014.
- [277] P.L. 113-93, §220(d)(2)(B)(ii), changed reference from (B)(ii)(II) to (B)(ii)(I). Effective April 1, 2014.
- [278] P.L. 113-93, §220(a)(1), added subparagraph (M). Effective April 1, 2014.
- [279] P.L. 113-93, §220(b), added subparagraph (N). Effective April 1, 2014.
- [280] P.L. 113-295, §202(2)(A), struck "2017 through 2020" and inserted "2016 through 2018". Effective December 19, 2014.
- [281] P.L. 113-295, §202(2)(B), struck "2017 " and inserted "2016 ". Effective December 19, 2014.
- [282] P.L. 113-93, §220(d), added subparagraph (O). Effective April 1, 2014.
- P.L. 113-295, §202(2)(C), inserted "(or, for 2016, 1.0 percent) ". Effective December 19, 2014.
- [283] See Vol. II, P.L. 101-508, §4104(c), with respect to physician pathology services.
- [284] P.L. 113-93, §220(e)(1), added paragraph (7). Effective April 1, 2014.
- P.L. 113-295, §202(3), struck "2017 " and inserted "2016 ". Effective December 19, 2014.
- [285] P.L. 114-10, §523(a); inserted paragraph (8). Effective April 16, 2015.
- [286] P.L. 114-10, §101(a)(1), inserted "and ending with 2025". Effective April 16, 2015.
- [287] P.L. 114-10, §101(a)(1), inserted "or a subsequent paragraph". Effective April 16, 2015.
- [288] P.L. 114-10, §101(a)(2), inserted text after "for the year involved.". Effective April 16, 2015.
- [289] P.L. 114-10, §101(a)(2), inserted "(or, beginning with 2026, applicable conversion factor)". Effective April 16, 2015.
- [290] P.L. 105-33, §4502(b); 111 Stat. 433.
- [291] P.L. 114-10, §101(a)(1), inserted "and ending with 2014". Effective April 16, 2015.
- [292] P.L. 114-10, §101(a)(1), inserted "and ending with 2014". Effective April 16, 2015.
- [293] P.L. 112-78, §301, added this new paragraph (13), effective December 23, 2011.
- [294] P.L. 112-96, §3003(a)(1), struck out "FIRST TWO MONTHS OF 2012" and inserted "2012", effective February 22, 2012.
- [295] P.L. 112-96, §3003(a)(2), struck out "the period beginning on January 1, 2012, and ending on February 29, 2012" and inserted "2012", effective February 22, 2012.
- [296] P.L. 112-96, §3003(a)(3), struck out "REMAINING PORTION OF 2012" and inserted "2013", effective February 22, 2012.

- [297] P.L. 112-96, §3003(a)(4), struck out “for the period beginning on March 1, 2012, and ending on December 31, 2012, and for 2013” and inserted “for 2013”, effective February 22, 2012.
- [298] P.L. 112-240, §601, added this new paragraph (14), effective January 2, 2013.
- [299] P.L. 113-93, §101(1)(A), struck “January through March of” effective April 1, 2014.
- [300] P.L. 113-93, §101(1)(B), struck “for the period beginning on January 1, 2014, and ending on March 31, 2014” effective April 1, 2014.
- [301] P.L. 113-67, §1101, inserted paragraph (d)(15). Effective December 26, 2013.
P.L. 113-93, §101(1)(C) struck references to 2014. Effective April 1, 2014.
- [302] P.L. 113-93, §101(2), inserted paragraph (d)(16). Effective April 1, 2014.
P.L. 114-10 §101(a)(2) Struck paragraph 16, inserted replacement paragraph 16 and new paragraphs 17 through 20. Effective April 15, 2015
- [303] See Vol. II, P.L. 112-96, §3004(b), with respect to a report regarding the work geographic adjustment..
- [304] P.L. 113-67, §1102, struck out “ January 1, 2014” and inserted “April 1, 2014*”, effective December 26, 2013.
P.L. 113-93 §102, struck out “ April 1, 2014” and inserted “April 1, 2015”, effective April 1, 2014.
**P.L. 114-10 §201, struck out “ April 1, 2015” and inserted “January 1, 2018”, effective April 16, 2015.
- [305] As in original. No subparagraph (F) was enacted.
- [306] As in original. The period was missing.
- [307] P.L. 113-93, §220(h)(1), added paragraph (6). Effective April 1, 2014.
- [308] P.L. 114-10, §101(a)(1), inserted “through 2014”. Effective April 16, 2015.
- [309] P.L. 114-10, §101(a)(1), inserted “and ending with 2014”. Effective April 16, 2015.
- [310] See Vol. II, P.L. 103-66, §13515(b).
- [311] P.L. 113-93, §220(a)(2)(A-C), added subparagraph (F). Effective April 1, 2014.
- [312] P.L. 113-93, §220(h)(2), inserted “Except as provided in subsection (e)(6)(D)”, Effective April 1, 2014.
- [313] See Vol. II, P.L. 101-508, §4117(a), with respect to Statewide fee schedule areas for physicians’ services.
- [314] P.L. 114-10, §101(a)(2)(B) Inserted paragraph (9). Effective April 16, 2015
- [315] See Vol. II, P.L. 110-275, §132(c), with respect to a GAO report on electronic prescribing.
- [316] P.L. 114-10, §101(d)(1)(A) inserted “for 2016 and subsequent years, may provide” after “shall provide”. Effective April 16, 2015.
- [317] P.L. 112-240, §601(b)(1)(B) added this new subparagraph (D), effective January 2, 2013.
- [318] P.L. 114-10, §101(d)(1)(B) inserted “and, for 2016 and subsequent years, subparagraph (A) or (C)” after “subparagraph (A)”. Effective April 16, 2015.
- [319] P.L. 112-240, §601(b)(1)(B), added this new subparagraph (E), effective January 2, 2013.
- [320] P.L. 112-240, §601(b)(1)(A), redesignated this former subparagraph (D) as subparagraph (F), effective January 2, 2013.
- [321] P.L. 114-10, §101(d)(2)(A) struck “and subsequent years’ and inserted “through reporting periods occurring in 2015” after “For 2008”. Effective April 16, 2015.
- [322] P.L. 114-10, §101(d)(2)(B) Inserted “and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish” after “shall establish”. Effective April 16, 2015.
- [323] P.L. 111-148, §3002(d), added this paragraph (7), effective March 23, 2010.
- [324] P.L. 111-148, §10327(a), added this second paragraph (7), effective March 23, 2010.
- [325] As in original.
- [326] P.L. 114-10 Sec 101(a)(2)(B) redesignated paragraph (m)(7) as (m)(8). Effective April 16, 2015
- [327] P.L. 114-10 Sec 101(a)(2)(B) inserted paragraph (m)(9). Effective April 16, 2015.
- [328] See Vol. II, 5 U.S.C. 552.
- [329] P.L. 114-10, §101(d)(3) Inserted paragraph. Effective April 16, 2015.
- [330] P.L. 114-10, §101(b)(1). Struck “For purposes of paragraph (1), an” and inserted “An”. Effective April 16, 2015
- [331] P.L. 114-10, §101(b)(1). Inserted “, or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year”. Effective April 16, 2015
- [332] P.L. 114-10, §106(b)(2)(A) In the last sentence, inserted “, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology” before the period. Effective April 16, 2015.
- [333] P.L. 114-10, §101(d)(3) Inserted “and subsection (q)(5)(B)(ii)(II)” after “subparagraph (B)(ii)”. Effective April 16, 2015.

[334] P.L. 114–10, §101(b)(1). Inserted paragraph (o)(2)(D). Effective April 16, 2015

* P.L. 114-255, §4002(b)(1)(B); inserted "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." at the end of the subparagraph. Effective December 10, 2016.

[335] P.L. 114–10, §101(b)(3). Inserted paragraph (p)(2)(C). Effective April 16, 2015

[336] P.L. 114–10, §101(b)(3). Inserted last sentence. Effective April 16, 2015

[337] P.L. 114–10, §101(b)(3). Replaced paragraph (p)(4)(B)(iii). Effective April 16, 2015

[338] P.L. 114-10, §101(c)(1) Added subsection "(q) Merit Based Incentive Payment System. Effective April 16, 2015.

[339] P.L. 114-10, §101(f) Added subsection "(r) Collaborating With the Physician, Practitioner, and Other Stakeholder Communities To Improve Resource Use Measurement." Effective April 16, 2015.

[340] P.L. 114-10, §102 Added subsection "(s) Priorities and Funding for Measure Development." Effective April 16, 2015.