

the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(ii) in the same amount for each Medicare fee-for-service beneficiary described in clause (i) or (ii) of subparagraph (B) without regard to enrollment of such a beneficiary in a medicare supplemental policy (described in section 1395ss(g)(1) of this title), in a State Medicaid plan under subchapter XIX or a waiver of such a plan, or in any other health insurance policy or health benefit plan;

(iii) made for each qualifying service furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B) during a period specified by the Secretary; and

(iv) made no later than 30 days after a qualifying service is furnished to such a beneficiary described in clause (i) or (ii) of subparagraph (B).

(E) No separate payments from the Secretary

The Secretary shall not make any separate payment to an ACO for the costs, including incentive payments, of carrying out an ACO Beneficiary Incentive Program established under this subsection. Nothing in this subparagraph shall be construed as prohibiting an ACO from using shared savings received under this section to carry out an ACO Beneficiary Incentive Program.

(F) No application to shared savings calculation

Incentive payments made by an ACO under this subsection shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings under this section.

(G) Reporting requirements

An ACO conducting an ACO Beneficiary Incentive Program under this subsection shall, at such times and in such format as the Secretary may require, report to the Secretary such information and retain such documentation as the Secretary may require, including the amount and frequency of incentive payments made and the number of Medicare fee-for-service beneficiaries receiving such payments.

(H) Termination

The Secretary may terminate an ACO Beneficiary Incentive Program established under this subsection at any time for reasons determined appropriate by the Secretary.

(3) Exclusion of incentive payments

Any payment made under an ACO Beneficiary Incentive Program established under this subsection shall not be considered income or resources or otherwise taken into account for purposes of—

(A) determining eligibility for benefits or assistance (or the amount or extent of benefits or assistance) under any Federal program or under any State or local program financed in whole or in part with Federal funds; or

(B) any Federal or State laws relating to taxation.

(Aug. 14, 1935, ch. 531, title XVIII, § 1899, as added and amended Pub. L. 111–148, title III, § 3022, title X, § 10307, Mar. 23, 2010, 124 Stat. 395, 940; Pub. L. 114–255, div. C, title XVII, § 17007, Dec. 13, 2016, 130 Stat. 1338; Pub. L. 115–123, div. E, title III, §§ 50324(a), 50331, 50341(a), Feb. 9, 2018, 132 Stat. 203, 205, 206.)

Editorial Notes

AMENDMENTS

2018—Subsec. (b)(2)(I). Pub. L. 115–123, § 50341(a)(1), added subpar. (I).

Subsec. (c). Pub. L. 115–123, § 50331, designated existing provisions as par. (1), inserted heading, substituted “Subject to paragraph (2), the Secretary” for “The Secretary”, redesignated former pars. (1) and (2) as subpars. (A) and (B), respectively, of par. (1), realigned margins, and added par. (2).

Subsec. (e). Pub. L. 115–123, § 50341(a)(3), inserted “, including an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)” after “the program”.

Subsec. (g)(6). Pub. L. 115–123, § 50341(a)(4), inserted “or of an ACO Beneficiary Incentive Program under subsections (b)(2)(I) and (m)” after “under subsection (d)(4)”.

Subsec. (l). Pub. L. 115–123, § 50324(a), added subsec. (l).

Subsec. (m). Pub. L. 115–123, § 50341(a)(2), added subsec. (m).

2016—Subsec. (c). Pub. L. 114–255 substituted “utilization of—” for “utilization of primary”, inserted par. (1) designation and “in the case of performance years beginning on or after April 1, 2012, primary” before “care services”, and added par. (2).

2010—Subsecs. (i) to (k). Pub. L. 111–148, § 10307, added subsecs. (i) to (k).

Statutory Notes and Related Subsidiaries

STUDY AND REPORT

Pub. L. 115–123, div. E, title III, § 50324(b), Feb. 9, 2018, 132 Stat. 204, provided that:

“(1) **STUDY.**—

“(A) **IN GENERAL.**—The Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall conduct a study on the implementation of section 1899(l) of the Social Security Act [42 U.S.C. 1395jjj(l)], as added by subsection (a). Such study shall include an analysis of the utilization of, and expenditures for, telehealth services under such section.

“(B) **COLLECTION OF DATA.**—The Secretary may collect such data as the Secretary determines necessary to carry out the study under this paragraph.

“(2) **REPORT.**—Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.”

§ 1395kkk. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(a), Feb. 9, 2018, 132 Stat. 298

Section, Aug. 14, 1935, ch. 531, title XVIII, § 1899A, as added and amended Pub. L. 111–148, title III, § 3403(a)(1), title X, § 10320(a), Mar. 23, 2010, 124 Stat. 489, 949, established the Independent Payment Advisory Board.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

Pub. L. 111–148, title X, § 10320(b), Mar. 23, 2010, 124 Stat. 952, which provided that any reference in the pro-

visions of, or amendments made by, section 3403 of Pub. L. 111-148 (enacting this section and section 1395kkk-1 of this title and amending section 1395b-6 of this title and section 207 of Title 18, Crimes and Criminal Procedure) to the “Independent Medicare Advisory Board” be deemed to be a reference to the “Independent Payment Advisory Board”, was repealed by Pub. L. 115-123, div. E, title XI, § 52001(b)(4), Feb. 9, 2018, 132 Stat. 298.

CONSTRUCTION

Pub. L. 111-148, title X, § 10320(c), Mar. 23, 2010, 124 Stat. 952, which provided that nothing in the amendments made by section 10320 of Pub. L. 111-148 precluded the Independent Medicare Advisory Board (renamed the Independent Payment Advisory Board) from solely using data from public or private sources to carry out former subsection (f)(3)(B) of this section, was repealed by Pub. L. 115-123, div. E, title XI, § 52001(b)(5), Feb. 9, 2018, 132 Stat. 298.

§ 1395kkk-1. Repealed. Pub. L. 115-123, div. E, title XI, § 52001(b)(2), Feb. 9, 2018, 132 Stat. 298

Section, Pub. L. 111-148, title III, § 3403(b), Mar. 23, 2010, 124 Stat. 506, related to GAO study and report on determination and implementation of payment and coverage policies under the Medicare program.

§ 1395III. Standardized post-acute care (PAC) assessment data for quality, payment, and discharge planning

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

- (i) standardized patient assessment data in accordance with subsection (b);
- (ii) data on quality measures under subsection (c)(1); and
- (iii) data on resource use and other measures under subsection (d)(1);

(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

- (i) provide for the submission of standardized patient assessment data under this subchapter with respect to such providers; and
- (ii) enable comparison of such assessment data across all such providers to whom such data are applicable.

(2) Definitions

For purposes of this section:

(A) Post-acute care (PAC) provider

The terms “post-acute care provider” and “PAC provider” mean—

- (i) a home health agency;
- (ii) a skilled nursing facility;
- (iii) an inpatient rehabilitation facility; and
- (iv) a long-term care hospital (other than a hospital classified under section 1395ww(d)(1)(B)(vi) of this title).

(B) PAC assessment instrument

The term “PAC assessment instrument” means—

- (i) in the case of home health agencies, the instrument used for purposes of reporting and assessment with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;
- (ii) in the case of skilled nursing facilities, the resident’s assessment under section 1395i-3(b)(3) of this title;
- (iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1395ww(j) of this title; and
- (iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754-51755), including for purposes of section 1395ww(m)(5)(C) of this title, or any other instrument used with respect to such hospitals for assessment purposes.

(C) Applicable reporting provision

The term “applicable reporting provision” means—

- (i) for home health agencies, section 1395fff(b)(3)(B)(v) of this title;
- (ii) for skilled nursing facilities, section 1395yy(e)(6) of this title;
- (iii) for inpatient rehabilitation facilities, section 1395ww(j)(7) of this title; and
- (iv) for long-term care hospitals, section 1395ww(m)(5) of this title.

(D) PAC payment system

The term “PAC payment system” means—

- (i) with respect to a home health agency, the prospective payment system under section 1395fff of this title;
- (ii) with respect to a skilled nursing facility, the prospective payment system under section 1395yy(e) of this title;
- (iii) with respect to an inpatient rehabilitation facility, the prospective payment system under section 1395ww(j) of this title; and
- (iv) with respect to a long-term care hospital, the prospective payment system under section 1395ww(m) of this title.

(E) Specified application date

The term “specified application date” means the following:

(i) Quality measures

In the case of quality measures under subsection (c)(1)—