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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R. _____

To amend title XVIII of the Social Security Act to modify certain physician payments under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

Mr. JOYCE of Pennsylvania introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to modify certain physician payments under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Patients First Act of
5 2026”.

1 **TITLE I—STRENGTHENING RE-**
2 **IMBURSEMENT AND PATIENT**
3 **ACCESS**

4 **SEC. 101. MODIFYING THE CONVERSION FACTOR UPDATES**
5 **APPLICABLE TO PHYSICIANS’ SERVICES**
6 **UNDER THE MEDICARE PROGRAM.**

7 (a) IN GENERAL.—Section 1848(d) of the Social Se-
8 curity Act (42 U.S.C. 1395w–4(d)) is amended—

9 (1) in paragraph (1)(A), in the second sentence,
10 by inserting “or (21)” after “paragraph (20)”;

11 (2) in paragraph (20)—

12 (A) in the header, by striking “AND SUB-
13 SEQUENT YEARS”; and

14 (B) by striking “and each subsequent
15 year”; and

16 (3) by adding at the end the following new
17 paragraph:

18 “(21) UPDATE FOR 2027 AND SUBSEQUENT
19 YEARS.—

20 “(A) IN GENERAL.—For 2027 and each
21 subsequent year, the update to the nonquali-
22 fying APM conversion factor established under
23 paragraph (1)(A) is, subject to subparagraph
24 (B), the Secretary’s estimate of the percentage
25 increase in the MEI (as defined in section

1 1842(i)(3)) for the year, less 1 percentage
2 point, and the update to the qualifying APM
3 conversion factor established under such para-
4 graph is the update to the nonqualifying APM
5 conversion factor for the year, increased by 0.5
6 percentage point.

7 “(B) FLOOR AND CEILING ON NONQUALI-
8 FYING APM CONVERSION FACTOR UPDATE.—In
9 the case that the update to the nonqualifying
10 APM conversion factor for a year as calculated
11 under subparagraph (A) is—

12 “(i) less than 25 percent of the Sec-
13 retary’s estimate of the percentage in-
14 crease in the MEI (as defined in section
15 1842(i)(3)) for the year, such update shall
16 be deemed to be equal to 25 percent of
17 such estimate; or

18 “(ii) more than 75 percent of such es-
19 timate, such update shall be deemed to be
20 equal to 75 percent of such estimate.”.

21 (b) REPORTS.—The Secretary of Health and Human
22 Services shall, for 2027 and each year thereafter, submit
23 to Congress a report on the updates to the qualifying APM
24 conversion factor and nonqualifying APM conversion fac-
25 tor under section 1848(d) of the Social Security Act (42

1 U.S.C. 1395w–4(d)) for such year. Such report shall in-
2 clude an analysis of the impact of such updates on Medi-
3 care beneficiaries’ access to services under the Medicare
4 program and on the consolidation of physician practices.

5 **SEC. 102. HYBRID PAYMENT MODEL FOR PRIMARY CARE**
6 **SERVICES.**

7 Part E of title XVIII of the Social Security Act (42
8 U.S.C. 1395x et seq.) is amended by inserting after sec-
9 tion 1866G the following new section:

10 **“SEC. 1866H. HYBRID PAYMENT MODEL FOR PRIMARY**
11 **CARE SERVICES.**

12 “(a) IN GENERAL.—The Secretary shall, for 2027
13 and each subsequent year through 2031, carry out a hy-
14 brid payment model for primary care services (in this sec-
15 tion referred to as the ‘model’) under which the Secretary
16 shall make a monthly payment to each qualifying supplier
17 for each individual attributed to such practice for such
18 year in lieu of payment for any designated primary care
19 services furnished by such supplier to such individuals
20 during such year that would otherwise be made under the
21 payment schedule established under section 1848 (or on
22 the basis of such schedule).

23 “(b) PAYMENT AMOUNT.—

24 “(1) IN GENERAL.—The monthly amount pay-
25 able to a qualifying supplier for a year under the

1 model is equal to one-twelfth of the national average
2 amount that the Secretary estimates will be payable
3 under the payment basis established under section
4 1848 for designated primary care services furnished
5 during such year (so estimated as if no cost sharing
6 requirements applied to individuals enrolled under
7 part B), adjusted by a geographic index determined
8 appropriate by the Secretary and risk adjusted in a
9 manner determined appropriate by the Secretary.

10 “(2) NONAPPLICATION OF COST SHARING.—No
11 cost sharing requirement shall apply with respect to
12 a monthly payment made under the model to a
13 qualifying supplier for an individual attributed to
14 such supplier.

15 “(c) ATTRIBUTION PROCESS.—

16 “(1) IN GENERAL.—The Secretary shall estab-
17 lish a process under which, for each year of the
18 model, individuals enrolled under part B who are not
19 enrolled under an MA plan under part C may des-
20 ignate a qualifying supplier as such individual’s pri-
21 mary care provider for such year.

22 “(2) ATTRIBUTION BASED ON PRIOR CLAIMS.—
23 In the case of an individual described in paragraph
24 (1) who fails to make a designation for a year but
25 for whom the Secretary determines, based on claims

1 history of items and services furnished under this
2 title, that such individual has a primary care pro-
3 vider who is a qualifying supplier, the Secretary may
4 designate such supplier as such individual's primary
5 care provider for such year.

6 “(3) TREATED AS ATTRIBUTED.—For purposes
7 of this section, each individual who makes a designa-
8 tion under paragraph (1) (or for whom such a des-
9 ignation is made under paragraph (2)) with respect
10 to a qualifying supplier for a year shall be treated
11 as attributed to such supplier for such year.

12 “(d) NO EFFECT ON PFS BUDGET NEUTRALITY.—
13 Section 1848(c)(2)(B) shall be applied for 2027 and each
14 subsequent year as if the model had never applied.

15 “(e) FUNDING.—Payments under the model shall be
16 made from the Federal Supplementary Medical Insurance
17 Trust Fund established under section 1841.

18 “(f) DEFINITIONS.—In this section:

19 “(1) DESIGNATED HEALTH CARE PRACTI-
20 TIONER.—The term ‘designated health care practi-
21 tioner’ means a physician assistant, a nurse practi-
22 tioner, a clinical nurse specialist, a physical thera-
23 pist, an occupational therapist, or such other health
24 care practitioner as the Secretary may specify.

1 “(2) DESIGNATED PRIMARY CARE SERVICES.—

2 The term ‘designated primary care services’
3 means—

4 “(A) care management services;

5 “(B) behavioral health integration services;

6 “(C) office-based evaluation and manage-
7 ment services (whether furnished in person or
8 via telehealth); and

9 “(D) communications such as telephone
10 calls, emails and patient portals between pa-
11 tients and their care givers.

12 “(3) EXCLUDED PRACTICE.—

13 “(A) IN GENERAL.—The term ‘excluded
14 practice’ means, subject to subparagraph (B),
15 any practice—

16 “(i) in which any entity that is not a
17 physician or designated health care practi-
18 tioner or a professional corporation, profes-
19 sional association, limited liability com-
20 pany, or other professional body that is
21 majority owned and controlled by physi-
22 cians or designated health care practi-
23 tioners has an ownership interest;

24 “(ii) in which any entity described in
25 subparagraph (A) exercises de facto con-

1 troll over employment decisions (including
2 rates of pay and terms of employment),
3 clinical staffing levels, amount of time
4 spent between a supplier and a patient, di-
5 agnostic or procedural coding decisions,
6 clinical standards or policy, billing and col-
7 lection, prices for items and services, con-
8 tracting with third party payors, or con-
9 trolling or restricting the practice's assets;

10 “(iii) in which physicians or des-
11 ignated health care practitioners hold 50
12 percent or less of voting shares or member-
13 ship interests;

14 “(iv) that has a governing board in
15 which physicians or designated health care
16 practitioners constitute less than 50 per-
17 cent of the members; or

18 “(v) in the case such practice is a cor-
19 poration or professional association, that
20 permits the removal of directors or officers
21 that are physicians or designated health
22 care practitioners except by majority vote
23 of stakeholders that are physicians or des-
24 ignated health care practitioners.

1 “(B) EXCEPTION.—The term ‘excluded
2 practice’ does not include any practice con-
3 sisting of 15 or fewer designated health care
4 practitioners.

5 “(4) SPECIFIED PRACTITIONER.—The term
6 ‘specified practitioner’ means—

7 “(A) a physician with a primary specialty
8 or practice area of family medicine, internal
9 medicine, geriatric medicine, or pediatric medi-
10 cine; or

11 “(B) a physician assistant, a nurse practi-
12 tioner, or a clinical nurse specialist.

13 “(5) QUALIFYING SUPPLIER.—The term ‘quali-
14 fying supplier’ means, with respect to a year, a spec-
15 ified practitioner—

16 “(A) who is not part of an excluded prac-
17 tice;

18 “(B) who furnished items and services
19 under this title during the preceding year;

20 “(C) for whom, with respect to payments
21 under this title for all items and services fur-
22 nished by such practitioner during the pre-
23 ceding year, at least 60 percent of such pay-
24 ments were for designated primary care serv-
25 ices; and

1 “(D) who has elected to participate in the
2 model for such year through such process as
3 the Secretary shall establish.”.

4 **SEC. 103. WORK GEOGRAPHIC FLOOR ADJUSTMENT FOR**
5 **HIGH INFLATIONARY YEARS.**

6 (a) IN GENERAL.—Section 1848(e)(1)(E) of the So-
7 cial Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amend-
8 ed—

9 (1) by striking the header and inserting “WORK
10 GEOGRAPHIC INDEX”;

11 (2) by striking “After calculating” and insert-
12 ing the following:

13 “(i) IN GENERAL.—After calculating”;

14 (3) in clause (i) (as so inserted)—

15 (A) by inserting “(or 1.025, in the case
16 such year is a high inflationary year (as defined
17 in clause (iii)))” after “to 1.00”; and

18 (B) by striking “2027” and inserting
19 “2032”; and

20 (4) by adding at the end the following new
21 clauses:

22 “(ii) INCREASE IN HIGH INFLA-
23 TIONARY YEARS FOR OTHER LOCAL-
24 ITIES.—After calculating the work geo-
25 graphic index in subparagraph (A)(iii), for

1 purposes of payment for services furnished
2 on or after January 1, 2027, and before
3 January 1, 2033, the Secretary shall in-
4 crease the work geographic index by .02
5 points if such year is a high inflationary
6 year, unless such work geographic index is
7 subject to an increase under clause (i) for
8 such year.

9 “(iii) DEFINITION.—In this subpara-
10 graph, the term ‘high inflationary year’
11 means a year if, over the 12-month period
12 ending on the last day of the preceding
13 year, the consumer price index for all
14 urban consumers (U.S. city average) in-
15 creased by more than 2 percent.

16 “(iv) PUBLICATION.—Medicare ad-
17 ministrative contractors shall publish the
18 geographically adjusted work relative value
19 units for both the inflation adjustments
20 under clauses (i) and (ii) and the work ge-
21 ographic adjustment for all services on a
22 quarterly basis effective January 1, 2027,
23 for each of their geographic areas.”.

24 (b) REPORT.—Not later than 1 year after the date
25 of the enactment of this Act, Comptroller General of the

1 United States shall submit to the House Energy and Com-
2 merce and Ways and Means Committees and Senate Fi-
3 nance Committee a study on the economic factors that are
4 impacting physician choice, by specialty, regarding the ge-
5 ographic area in which such physicians choose to practice,
6 including salaries, contract terms, cost of living, avail-
7 ability of capital, volume of services, and costs to conduct
8 a practice.

9 **TITLE II—POINTS**

10 **SEC. 201. IMPLEMENTATION OF THE PATIENT OUTCOME** 11 **IMPROVEMENT NATIONAL TABULATION SYS-** 12 **TEM.**

13 (a) IN GENERAL.—Effective January 1, 2032, there
14 is established the Patient Outcome Improvement National
15 Tabulation System, which shall consist of the payment
16 system under section 1848(q) of the Social Security Act
17 (42 U.S.C. 1395w–4(q)), including as amended by this
18 section.

19 (b) REFERENCES.—Subject to paragraph (3), any
20 reference to the payment system under section 1848(q)
21 of the Social Security Act (42 U.S.C. 1395w–4(q)), includ-
22 ing the terms “Merit-based Incentive Payment System”
23 and “MIPS”, shall be deemed a reference to the “Patient
24 Outcome Improvement National Tabulation System” and
25 “POINTS”, respectively.

1 (c) TRANSITION.—In order to provide for an orderly
2 transition and avoid provider confusion, the Secretary of
3 Health and Human Services shall provide for an appro-
4 priate transition in the use of the terms “Merit-based In-
5 centive Payment System” (and “MIPS”) and “Patient
6 Outcome Improvement National Tabulation System” (and
7 “POINTS”) in reference to the payment system under
8 section 1848(q) of the Social Security Act (42 U.S.C.
9 1395w–4(q)). Before the completion of such transition,
10 any reference to the “Patient Outcome Improvement Na-
11 tional Tabulation System” (or “POINTS”) shall be
12 deemed to include a reference to the “Merit-based Incen-
13 tive Payment System”.

14 **SEC. 202. PAYMENT REFORM.**

15 (a) IN GENERAL.—Section 1848(q) of the Social Se-
16 curity Act (42 U.S.C. 1395w–4(q)) is amended—

17 (1) in paragraph (1)(D)(i)(II), by striking
18 “(iv)” and inserting “(v)”;

19 (2) in paragraph (2)—

20 (A) in subparagraph (A)—

21 (i) in clause (iii), by striking “Clinical
22 practice” and inserting “For performance
23 periods beginning before January 1, 2032,
24 clinical practice”;

1 (ii) in clause (iv), by striking “Mean-
2 ingful use” and inserting “For perform-
3 ance periods before January 1, 2032,
4 meaningful use”; and

5 (iii) by adding at the end the fol-
6 lowing new clause:

7 “(v) For performance periods begin-
8 ning on or after January 1, 2032, care ef-
9 ficiency.”;

10 (B) in subparagraph (B)—

11 (i) in clause (ii)—

12 (I) by striking “subparagraph
13 (A)(ii), the measurement” and insert-
14 ing the following: “subparagraph
15 (A)(ii)—

16 “(I) for performance periods be-
17 ginning before January 1, 2032, the
18 measurement”; and

19 (II) by striking the period at the
20 end and inserting the following: “;
21 and

22 “(II) for performance periods be-
23 ginning on or after January 1, 2032,
24 the measurement described in sub-
25 clause (I) and any resource use meas-

1 ures included in the final measures
2 list published under subparagraph
3 (D)(i) for such period.”; and
4 (ii) by inserting after clause (iv) the
5 following new clause:

6 “(v) CARE EFFICIENCY.—For the per-
7 formance category described in subpara-
8 graph (A)(v), care efficiency measures
9 (such as measures relating to reductions in
10 avoidable hospitalizations, reductions in
11 medication burden (when clinically appro-
12 priate), reductions in complications from
13 chronic diseases, and referral patterns to
14 the lowest-cost clinically appropriate set-
15 tings) included in the final measures list
16 published under subparagraph (D)(i) for
17 such period.”;

18 (C) in subparagraph (D)—

19 (i) in the header, by striking “QUAL-
20 ITY”;

21 (ii) in clause (i)—

22 (I) in the matter preceding sub-
23 clause (I), by inserting “(or, with re-
24 spect to performance periods begin-
25 ning on or after January 1, 2032, an

1 annual final list of quality measures,
2 resource use measures (if determined
3 appropriate by the Secretary), and
4 care efficiency measures)” after
5 “quality measures”; and

6 (II) in subclause (II)—

7 (aa) in item (aa), by striking
8 “quality measures” and inserting
9 “measures”;

10 (bb) in item (bb), by insert-
11 ing “(or, with respect to a final
12 list for a performance period be-
13 ginning on or after January 1,
14 2032, new quality measures, re-
15 source use measures, or care effi-
16 ciency measures)” after “quality
17 measures”; and

18 (cc) in item (cc), by striking
19 “quality measures” and inserting
20 “measures”;

21 (iii) in clause (ii)—

22 (I) in the header, by striking
23 “quality”; and

24 (II) in subclause (I)—

1 (aa) by inserting “(or, with
2 respect to such an annual list for
3 a performance period beginning
4 on or after January 1, 2032,
5 quality measures, resource use
6 measures, and care efficiency
7 measures)” after “submit quality
8 measures”; and

9 (bb) by striking “quality
10 measures published” and insert-
11 ing “measures published”;

12 (iv) in clause (iii)—

13 (I) in the matter preceding sub-
14 clause (I), by striking “quality”;

15 (II) in subclause (I), by striking
16 “and” at the end;

17 (III) in subclause (II)—

18 (aa) by striking “ensure
19 that” and inserting “with respect
20 to such an annual final list for a
21 performance period beginning be-
22 fore January 1, 2032, ensure
23 that”; and

1 (bb) by striking the period
2 at the end and inserting “; and”;
3 and

4 (IV) by adding at the end the fol-
5 lowing new subclause:

6 “(III) with respect to such an an-
7 nual final list for a performance pe-
8 riod beginning on or after January 1,
9 2032, provide that—

10 “(aa) no quality measure
11 applicable to a medical specialty
12 is included on such list if—

13 “(AA) the task force
14 established under subpara-
15 graph (E) has issued rec-
16 ommendations on quality
17 measures for use under this
18 subsection with respect to
19 such specialty; and

20 “(BB) the quality
21 measure does not have in ef-
22 fect such a recommendation;
23 and

24 “(bb) no resource use meas-
25 ure or care efficiency measure is

1 included on such list unless such
2 measure has in effect a rec-
3 ommendation from such task
4 force.”;

5 (v) in clause (v), in the matter pre-
6 ceding subclause (I), by inserting “for a
7 performance period beginning before Janu-
8 ary 1, 2032,” after “published under
9 clause (i)”;

10 (vi) in clause (vi), by striking “under
11 clauses (i), (iv), and (v)” and inserting
12 “under this subparagraph”; and

13 (vii) in clause (vii)(II), by striking
14 “shall be” and inserting “subject to clause
15 (iii)(III)(aa), shall be”;

16 (3) in paragraph (5)—

17 (A) in subparagraph (B)—

18 (i) in clause (ii)—

19 (I) in subclause (I)—

20 (aa) by striking “encourage”
21 and inserting “with respect to a
22 performance period beginning be-
23 fore January 1, 2032, encour-
24 age”; and

1 (bb) by striking “and” at
2 the end;

3 (II) in subclause (II), by striking
4 the period and inserting “; and”; and
5 (III) by adding at the end the
6 following new subclause:

7 “(III) with respect to a perform-
8 ance period beginning on or after Jan-
9 uary 1, 2032, with respect to a year,
10 provide that in the case of a MIPS el-
11 igible professional who fails to report
12 on an applicable quality measure
13 through the use of certified EHR
14 technology or clinical data registries,
15 the professional shall be treated as
16 achieving the lowest potential score
17 applicable to such measure.”; and

18 (ii) by adding at the end the following
19 new clause:

20 “(iii) INCENTIVE TO REPORT ON CER-
21 TAIN MEASURES.—

22 “(I) IN GENERAL.—With respect
23 to performance periods for years be-
24 ginning on or after January 1, 2027,
25 in the case a MIPS eligible profes-

1 sional elects to report on a measure
2 for such period that, with respect to
3 such professional and such period, is
4 a new measure described in subclause
5 (II), a substantively changed measure
6 described in subclause (III), or a
7 measure described in paragraph
8 (2)(B)(i) for which the Secretary is
9 unable to establish a benchmark, such
10 professional shall be treated as achiev-
11 ing the highest possible score with re-
12 spect to such measure.

13 “(II) NEW MEASURES.—For pur-
14 poses of subclause (I), a new measure
15 described in this subclause, with re-
16 spect to a MIPS eligible professional
17 and performance period for a year, is
18 a measure applicable to such profes-
19 sional with respect to the performance
20 category described in paragraph
21 (2)(A)(i) that is included in the final
22 list of quality measures published
23 under paragraph (2)(D)(i) (or the list
24 of quality measures described in para-
25 graph (2)(D)(vi) used by qualified

1 clinical data registries under sub-
2 section (m)(3)(E)) for such year but
3 was not included in such final list
4 under paragraph (2)(D)(i) (or list
5 under paragraph (2)(D)(vi)) for any
6 of the previous 3 years.

7 “(III) SUBSTANTIVELY CHANGED
8 MEASURE.—For purposes of subclause
9 (I), a substantively changed measure
10 described in this subclause, with re-
11 spect to a MIPS eligible professional
12 and performance period for a year, is
13 a measure applicable to such profes-
14 sional with respect to the performance
15 category described in paragraph
16 (2)(A)(i) that is included in the final
17 list of quality measures published
18 under paragraph (2)(D)(i) (or the list
19 of quality measures described in para-
20 graph (2)(D)(vi) used by qualified
21 clinical data registries under sub-
22 section (m)(3)(E)) for such year and
23 each of the previous three years but
24 that underwent a substantive change
25 (as defined by the Secretary) during

1 any of such previous three years.”;

2 and

3 (B) in subparagraph (E)—

4 (i) in clause (i)—

5 (I) in subclause (I)(aa), by in-
6 serting “(or, with respect to 2032 and
7 subsequent years, 65 percent)” after
8 “thirty percent”;

9 (II) in subclause (II)(aa), by in-
10 serting “(or, with respect to 2032 and
11 subsequent years, 20 percent)” after
12 “thirty percent”;

13 (III) in subclause (III), by insert-
14 ing “(or, with respect to 2032 and
15 subsequent years, 0 percent)” after
16 “fifteen percent”;

17 (IV) in subclause (IV), by insert-
18 ing “(or, with respect to 2032 and
19 subsequent years, 0 percent)” after
20 “twenty-five percent”; and

21 (V) by adding at the end the fol-
22 lowing new subclause:

23 “(V) CARE EFFICIENCY.—With
24 respect to 2032 and subsequent years,
25 15 percent of such score shall be

1 based on performance with respect to
2 the category described in clause (v) of
3 paragraph (2)(A).”; and

4 (ii) in clause (ii), by inserting “(before
5 2032)” after “In any year”;

6 (4) in paragraph (11)(A)(i), by striking
7 “clauses (i) through (iv) of”; and

8 (5) in paragraph (12)(A)(i)(II), by striking
9 “and (iv)” and inserting “through (v)”.

10 (b) IMPROVEMENTS TO RESOURCE USE PERFORM-
11 ANCE CATEGORY.—Section 1848(r) of the Social Security
12 Act (42 U.S.C. 1395w-4(r)) is amended—

13 (1) in paragraph (2)(H), by adding at the end
14 the following new sentence: “In making such revi-
15 sions for 2027 and subsequent years, the Secretary
16 shall revise care episode groups and patient condi-
17 tion groups without regard to any target described
18 in subparagraph (D)(i)(I).”; and

19 (2) in paragraph (5)(C)(i)—

20 (A) by inserting “, for years before 2027,”
21 after “shall”; and

22 (B) by inserting “and shall, for 2027 and
23 subsequent years, use such care episode codes
24 and patient condition codes” before the period.

1 **SEC. 203. QUALITY REFORM TASK FORCE.**

2 Section 1848(q)(2) of the Social Security Act (42
3 U.S.C. 1395w-4(q)(2)) is amended by adding at the fol-
4 lowing new subparagraph:

5 “(E) QUALITY REFORM TASK FORCE.—

6 “(i) IN GENERAL.—Not later than 6
7 months after the date of the enactment of
8 this subparagraph, the Secretary shall es-
9 tablish a Quality Reform Task Force (in
10 this subparagraph referred to as the ‘Task
11 Force’) for purposes of issuing rec-
12 ommendations with respect to the use of
13 quality, resource use, and care efficiency
14 measures under this subsection.

15 “(ii) MEMBERSHIP.—

16 “(I) IN GENERAL.—Members of
17 the Task Force shall be appointed by
18 the Secretary and shall include—

19 “(aa) representatives of the
20 Department of Health and
21 Human Services;

22 “(bb) representatives of eli-
23 gible professional organizations
24 (as defined in subparagraph
25 (D)(ii)(II)); and

1 “(cc) other experts deter-
2 mined appropriate by the Sec-
3 retary.

4 “(II) APPROPRIATE REPRESENTATION.—In making appointments
5 under subclause (I), the Secretary
6 shall ensure that—
7

8 “(aa) each medical specialty
9 or subspecialty as determined ap-
10 propriate by the Secretary in
11 which a MIPS eligible profes-
12 sional may practice is adequately
13 represented on the Task Force
14 through a relevant organization
15 described in subclause (I)(bb) if
16 a measure relating to such spe-
17 cialty or subspecialty is under
18 consideration;

19 “(bb) a majority of the Task
20 Force is comprised of designated
21 health care practitioners (as de-
22 fined in section 1866H(f)) or
23 representatives of designated
24 health care professional-led pro-

1 professional organizations described
2 in subclause (I)(bb);

3 “(cc) not more than 3 mem-
4 bers of the Task Force are rep-
5 resentatives of group health
6 plans, health insurance issuers,
7 or Medicare Advantage organiza-
8 tions; and

9 “(dd) at least 1 designated
10 health care practitioner who is
11 not part of an excluded practice
12 (as defined in section 1866H(f))
13 who practices in a medical spe-
14 cialty or subspecialty is included
15 on the Task Force when the
16 Task Force is considering meas-
17 ures relating to such specialty or
18 subspecialty.

19 “(III) MAXIMUM NUMBER OF
20 MEMBERS.—The number of members
21 of the Task Force may not exceed 25.

22 “(iii) DUTIES.—

23 “(I) IN GENERAL.—The Task
24 Force shall, with respect to each per-

1 performance period beginning on or after
2 January 1, 2032—

3 “(aa) issue recommendations
4 on quality, resource use, and care
5 efficiency measures for use under
6 this subsection; and

7 “(bb) update any rec-
8 ommendations previously issued
9 by the Task Force as determined
10 appropriate by the Task Force.

11 “(II) REQUIREMENTS.—The
12 Task Force—

13 “(aa) shall ensure that any
14 measure recommended under
15 subclause (I) conforms with ap-
16 plicable clinical guidelines devel-
17 oped by a professional organiza-
18 tion representing the medical
19 specialty or subspecialty to be
20 subject to such measure and is
21 designed to promote quality of
22 care, improve resource use, or re-
23 duce costs;

24 “(bb) may only recommend
25 a quality measure to the extent

1 that data for such measure can
2 be submitted through certified
3 EHR technology, administrative
4 or billing claims, or a qualified
5 clinical data registry;

6 “(cc) shall take into account
7 the circumstances of practitioners
8 in specialty types that furnish
9 services that do not typically in-
10 volve face-to-face interaction with
11 patients (or that typically involve
12 such interaction only at the di-
13 rection of another practitioner or-
14 dering such services);

15 “(dd) shall, in reviewing
16 measures and making rec-
17 ommendations, take into ac-
18 count—

19 “(AA) how the measure
20 relates to an episode of care
21 or a continuum of health
22 care, as applicable, involved;

23 “(BB) the context of
24 the respective performance
25 category of such measure

1 and how the measure may
2 serve to complement or align
3 with measures applicable in
4 other performance categories
5 under this subsection;

6 “(CC) measures devel-
7 oped by qualified clinical
8 data registries; and

9 “(DD) consult with
10 such registries as necessary
11 in the development and eval-
12 uation of measures; and

13 “(ee) ensure that the role of
14 qualified clinical data registries
15 in the development, maintenance,
16 and refinement of measures is
17 preserved or strengthened.

18 “(iv) SECRETARIAL RESPONSE TO
19 RECOMMENDATIONS.—

20 “(I) IN GENERAL.—Not later
21 than 120 days after the Task Force
22 issues recommendations with respect
23 to measures for a performance period,
24 the Secretary shall transmit to the
25 Task Force and to the Committee on

1 Ways and Means and the Committee
2 on Energy and Commerce of the
3 House of Representatives and the
4 Committee on Finance of the Senate
5 a formal written response that, with
6 respect to each such recommendation,
7 affirmatively states one of the fol-
8 lowing:

9 “(aa) The Secretary will im-
10 plement the recommendation as
11 issued.

12 “(bb) The Secretary will im-
13 plement the recommendation
14 with specified modifications, ac-
15 companied by a written expla-
16 nation of the modifications and
17 the clinical, administrative, or
18 program integrity basis for each
19 such modification.

20 “(cc) The Secretary will im-
21 plement the recommendation in
22 part, accompanied by a written
23 explanation of which elements
24 will be implemented and the basis
25 for declining the remainder.

1 “(dd) The Secretary declines
2 to implement the recommenda-
3 tion, accompanied by a detailed
4 written explanation of the clin-
5 ical, administrative, or program
6 integrity basis for the decision.

7 “(II) INCLUSION OF MEAS-
8 URES.—

9 “(aa) IN GENERAL.—The
10 Secretary shall include a measure
11 receiving a recommendation from
12 the Task Force for a perform-
13 ance period in the final measures
14 list published under subpara-
15 graph (D)(i) for such perform-
16 ance period unless the Secretary,
17 not later than 90 days after re-
18 ceiving the recommendation, pub-
19 lishes in the Federal Register a
20 written determination explaining
21 the specific clinical, administra-
22 tive, or program integrity basis
23 for excluding the measure.

24 “(bb) FURTHER REQUIRE-
25 MENTS FOR CERTAIN REC-

1 OMMENDATIONS.—Notwith-
2 standing item (aa), with respect
3 to any measure recommended by
4 the Task Force for a perform-
5 ance period with the support of
6 not fewer than 75 percent of the
7 members of the Task Force, the
8 Secretary may not exclude such
9 measure from the final measures
10 list published under subpara-
11 graph (D)(i) for such perform-
12 ance period unless the Sec-
13 retary—

14 “(AA) consults with the
15 task force regarding such
16 proposed exclusion; and

17 “(BB) includes in the
18 written determination under
19 subclause (I) a response to
20 the Task Force’s position
21 and a specific finding that
22 the basis for exclusion out-
23 weighs the clinical judgment
24 of the Task Force.

1 “(III) ANNUAL REPORT.—Not
2 later than March 1 of each year be-
3 ginning with the first calendar year
4 after the Task Force issues its initial
5 recommendations, the Secretary shall
6 submit to the Committee on Ways and
7 Means and the Committee on Energy
8 and Commerce of the House of Rep-
9 resentatives and the Committee on Fi-
10 nance of the Senate, and shall make
11 publicly available on the website of the
12 Centers for Medicare & Medicaid
13 Services, a report that includes, for
14 each recommendation issued by the
15 Task Force during the preceding cal-
16 endar year—

17 “(aa) the text of the rec-
18 ommendation and the vote of the
19 Task Force;

20 “(bb) the Secretary’s re-
21 sponse under subclause (I);

22 “(cc) the outcome with re-
23 spect to the final measures list
24 published under subparagraph
25 (D)(i), including whether the rec-

1 ommended measure was included,
2 included with modifications, or
3 excluded; and

4 “(dd) if the measure was ex-
5 cluded or modified, the written
6 justification provided under sub-
7 clause (I).”.

8 **SEC. 204. MODIFICATION OF MIPS PAYMENT ADJUST-**
9 **MENTS.**

10 (a) IN GENERAL.—Section 1848(q)(6)(B) of the So-
11 cial Security Act (42 U.S.C. 1395w–4(q)(6)(B)) is amend-
12 ed—

13 (1) in clause (iii), by striking “and” at the end;

14 (2) in clause (iv), by amending such clause to
15 read as follows:

16 “(iv) for 2022 and subsequent years
17 (through 2031), 9 percent;”; and

18 (3) by adding at the end the following new
19 clauses:

20 “(v) for 2032, 3 percent;

21 “(vi) for 2033, 4 percent; and

22 “(vii) for 2034, 5 percent.”.

23 (b) NO REDUCTION IN CASE OF FAILURE TO PRO-
24 VIDE FEEDBACK.—

1 (1) IN GENERAL.—Section 1848(q)(6) of the
2 Social Security Act (42 U.S.C. 1395w–4(q)(6)) is
3 amended by adding at the end the following new
4 subparagraph:

5 “(G) NO REDUCTION IN PAYMENTS IN
6 CASE OF FAILURE TO PROVIDE FEEDBACK.—
7 Notwithstanding the preceding provisions of
8 this paragraph, in the case that the Secretary
9 fails to provide a MIPS eligible professional
10 feedback required under paragraph (12) with
11 respect to the performance of such professional
12 for a performance period with respect to a year
13 for administrative claims-based measures in-
14 cluded in the performance categories described
15 in subparagraph (A)(i)(II) of such paragraph, if
16 application of subparagraph (E) would result in
17 a negative adjustment to payment for covered
18 professional services furnished by such profes-
19 sional during such year, the product otherwise
20 determined under such subparagraph for such
21 professional and year shall be deemed to be
22 zero.”.

23 (2) MODIFICATION OF FEEDBACK REQUIRE-
24 MENTS.—Section 1848(q)(12) of the Social Security
25 Act (42 U.S.C. 1395w–4(q)(12)) is amended—

1 (A) in subparagraph (A)(i)(II), by insert-
2 ing “(and, beginning with 2032, shall, on a
3 quarterly basis and with respect to administra-
4 tive claims-based measures in accordance with
5 clause (vi))” after “may”; and

6 (B) by adding at the end the following new
7 clause:

8 “(vi) FEEDBACK ON ADMINISTRATIVE-
9 CLAIMS BASED MEASURES.—With respect
10 to quarters beginning on or after January
11 1, 2032, the Secretary shall, not later than
12 60 days after each such quarter, provide to
13 each MIPS eligible professional, with re-
14 spect administrative claims-based measures
15 included in the performance categories de-
16 scribed in subparagraph (A)(i)(II), feed-
17 back on such professional’s performance,
18 including—

19 “(I) a description of the patients
20 and episodes attributed with respect
21 to such measures for purposes of as-
22 sessing the performance of such pro-
23 fessional during such quarter;

24 “(II) an identification of the
25 items and services furnished by such

1 professional or another individual that
2 will contribute to the assessment of
3 the performance of such professional
4 during such quarter with respect to
5 such measures; and

6 “(III) an identification of wheth-
7 er each item or service identified
8 under subitem (BB) for the quarter
9 was furnished by such professional or
10 another individual (and, in the case
11 that the performance of such profes-
12 sional for such quarter with respect to
13 such measures is assessed based on
14 participation in a group practice or
15 other group, whether each such item
16 or service was furnished by such pro-
17 fessional, another individual in such
18 group, or another individual outside of
19 such group).”.

20 (c) EXTENSION OF ADDITIONAL INCENTIVE PAY-
21 MENTS FOR CERTAIN PROFESSIONALS.—Section
22 1848(q)(6) of the Social Security Act (42 U.S.C. 1395w-
23 4(q)(6)) is amended—

24 (1) in subparagraph (C)—

1 (A) by inserting “and for 2032 and each
2 subsequent year” after “2024,”; and

3 (B) by inserting “(other than, with respect
4 to 2032 and each subsequent year, such a pro-
5 fessional that is part of an excluded practice (as
6 defined in section 1866H(f)))” after “MIPS eli-
7 gible professional”; and

8 (2) in subparagraph (F)(iv)(I), by inserting
9 “and for 2032 and each subsequent year” before the
10 period.

11 (d) REDUCTION IN POSITIVE ADJUSTMENTS FOR
12 CERTAIN PROFESSIONALS.—Section 1848(q)(6) of the
13 Social Security Act (42 U.S.C. 1395w–4(q)(6)), as amend-
14 ed by paragraph (1), is further amended by adding at the
15 end the following new subparagraph:

16 “(H) REDUCTION IN POSITIVE ADJUST-
17 MENTS FOR CERTAIN PROFESSIONALS.—The
18 Secretary shall reduce each positive MIPS ad-
19 justment factor otherwise determined under this
20 paragraph for a year (beginning with 2032) for
21 a MIPS eligible professional who is part of an
22 excluded practice (as defined in section
23 1866H(f)) by 50 percent. The preceding sen-
24 tence shall be applied in a budget neutral man-
25 ner.”.

1 **SEC. 205. MODIFYING REQUIREMENTS AND APPROVAL PE-**
2 **RIODS FOR QUALIFIED CLINICAL DATA REG-**
3 **ISTRIES.**

4 Section 1848(m)(3)(E) of the Social Security Act (42
5 U.S.C. 1395w-4(m)(3)(E)) is amended—

6 (1) in clause (i), by adding at the end the fol-
7 lowing: “Beginning January 1, 2027, such require-
8 ments shall include a requirement that the entity—

9 “(I) be established and operated
10 by a professional society that is con-
11 trolled or led by a designated practi-
12 tioner (as defined in section 1866H)
13 and that has demonstrated expertise
14 in developing evidence-based clinical
15 practice guidelines and quality meas-
16 ures for improving patient outcomes;

17 “(II) demonstrates adherence to
18 data quality and fidelity standards, in-
19 cluding standards relating to data ele-
20 ments, data completeness, and valida-
21 tion processes;

22 “(III) demonstrates capacity to
23 generate timely, actionable feedback
24 to participating practitioners to sup-
25 port continuous quality improvement

1 and track practitioner use of such
2 feedback;

3 “(IV) demonstrate transparency
4 in measure development (including the
5 methodology used in such measures
6 and any risk adjustment used in such
7 measures); and

8 “(V) has established self-audit or
9 review processes focusing on data ac-
10 curacy, measure integrity, and appro-
11 priate use of results.”; and

12 (2) in clause (v), by adding the following flush
13 matter at the end:

14 “A determination or designation made
15 under this clause on or after January 1,
16 2027, shall be effective for a period of 3
17 years. At the end of such period, the Sec-
18 retary (or, in the case of a designation
19 made by an organization, such organiza-
20 tion) may extend such determination or
21 designation (as applicable) for subsequent
22 3-year periods based on a showing by such
23 entity that such entity continues to meet
24 the requirements of clause (i).”.

1 **SEC. 206. EXPANDED ACCESS TO CLAIMS DATA TO FACILI-**
2 **TATE RESEARCH AND QUALITY IMPROVE-**
3 **MENT.**

4 (a) IN GENERAL.—Not later than January 1, 2027,
5 the Secretary of Health and Human Services shall estab-
6 lish a process to allow a qualified clinical data registry
7 under section 1848(m)(3)(E) of the Social Security Act
8 (42 U.S.C. 1395w–4(m)(3)(E)) or a clinician-led clinical
9 data registry under section 4005 of the 21st Century
10 Cures Act (Public Law 114–255) to request claims data
11 described in subsection (b) (in a form and manner deter-
12 mined to be appropriate by the Secretary) for the purposes
13 of—

14 (1) linking such data with clinical outcomes
15 data;

16 (2) conducting quality assessments and quality
17 improvement activities of providers of services (as
18 defined in subsection (u) of section 1861 of the So-
19 cial Security Act (42 U.S.C. 1395x) and suppliers
20 (as defined in subsection (d) of such section)), re-
21 porting the results of such assessments and activities
22 to such providers and suppliers, and performing
23 risk-adjusted, scientifically valid analyses and re-
24 search to support quality improvement or patient
25 safety; and

1 (3) publishing research and quality improve-
2 ment analyses, which may include deidentified com-
3 bined claims and clinical outcomes data.

4 (b) CLAIMS DATA DESCRIBED.—For purposes of
5 subsection (a), the claims data described in this sub-
6 section—

7 (1) are—

8 (A) claims data under the Medicare pro-
9 gram under title XVIII of the Social Security
10 Act (42 U.S.C. 1395 et seq.); and

11 (B) if the Secretary determines appro-
12 priate, claims data under the Medicaid program
13 under title XIX of such Act (42 U.S.C. 1396 et
14 seq.) and the State Children’s Health Insurance
15 Program under title XXI of such Act (42
16 U.S.C. 1397aa et seq.); and

17 (2) may include provider-specific claims data,
18 clinical specialty-specific claims data, State-specific
19 claims data, or nationwide claims data.

20 (c) TREATMENT OF QUALIFIED CLINICAL DATA
21 REGISTRIES AND CLINICIAN-LED CLINICAL DATA REG-
22 ISTRIES.—For the purposes of this section, qualified clin-
23 ical data registries and clinician-led clinical data registries
24 shall not be required to be qualified entities, as defined
25 in section 1874(e)(2) of the Social Security Act (42 U.S.C.

1 1395kk(e)(2)), or quasi-qualified entities, to access claims
2 data pursuant to subsection (a).

3 (d) FEE.—Data described in subsection (b) shall be
4 made available to a qualified clinical data registry or clini-
5 cian-led clinical data registry under this section at a rea-
6 sonable fee equal to the cost of making such data avail-
7 able. Any fee collected pursuant to the preceding sentence
8 shall be deposited into the Centers for Medicare & Med-
9 icaid Services Program Management Account.

10 **SEC. 207. MODIFICATION OF APPROPRIATE USE CRITERIA**

11 **DATA COLLECTION FOR APPLICABLE IMAG-**
12 **ING SERVICES.**

13 (a) IN GENERAL.—Section 1834(q) of the Social Se-
14 curity Act (42 U.S.C. 1395m(q)) is amended—

15 (1) in paragraph (3)(B)(ii)—

16 (A) in subclause (IV), by striking “gen-
17 erates and provides to the ordering professional
18 a certification or documentation that”; and

19 (B) by adding at the end the following new
20 subclause:

21 “(VIII) Beginning January 1,
22 2027, the mechanism provides to the
23 Secretary—

1 “(aa) the information de-
2 scribed in subclauses (III) and
3 (IV);

4 “(bb) the information de-
5 scribed in paragraph (4)(B); and

6 “(cc) such other information
7 as the Secretary determines to be
8 appropriate, at such time, and in
9 such form and manner, as the
10 Secretary may specify.”;

11 (2) in paragraph (4)—

12 (A) in subparagraph (A), by striking
13 clause (ii) and inserting the following:

14 “(ii) beginning January 1, 2027, com-
15 ply with such requirements as the Sec-
16 retary may establish.”;

17 (B) in subparagraph (B)—

18 (i) in the heading, by striking “FUR-
19 NISHING PROFESSIONAL” and inserting
20 “QUALIFIED CLINICAL DECISION SUPPORT
21 MECHANISM”;

22 (ii) in the matter preceding clause
23 (i)—

1 (I) by striking “with January 1,
2 2017” and inserting “January 1,
3 2027”; and

4 (II) by striking “payment for
5 such service may only be made if the
6 claim for the service includes” and in-
7 serting “the qualified decision support
8 mechanism shall maintain and report
9 to the Secretary under subparagraph
10 (F)”; and

11 (iii) in clause (iii), by striking “(if dif-
12 ferent from the furnishing professional)”; and

13 (C) in subparagraph (C), by adding at the
14 end the following new clauses:

15 “(iv) CLINICAL TRIALS.—An applica-
16 ble imaging service that is ordered for an
17 individual as part of a clinical trial.

18 “(v) SMALL AND RURAL PRAC-
19 TICES.—An applicable imaging service or-
20 dered by an ordering professional prac-
21 ticing in a small practice (consisting of 15
22 or fewer ordering professionals), or a prac-
23 tice in a health professional shortage area
24 (as designated under section 332(a)(1)(A)

1 of the Public Health Service Act) located
2 in a rural area.

3 “(vi) SPECIFIED EXEMPTIONS.—The
4 following types of applicable imaging serv-
5 ices:

6 “(I) A mammography.

7 “(II) A lung cancer screening
8 performed using computed tomog-
9 raphy.

10 “(III) A colonography performed
11 using computed tomography.

12 “(IV) Such a service furnished to
13 treat an emergency medical condition
14 or a suspected emergency medical
15 condition.

16 “(V) Such other preventive or
17 screening imaging services as the Sec-
18 retary determines appropriate.”;

19 (D) in subparagraph (D), by adding at the
20 end the following new clause:

21 “(iv) Any other payment system de-
22 termined appropriate by the Secretary.”;
23 and

24 (E) by adding at the end the following new
25 subparagraphs:

1 “(E) FURNISHING PROFESSIONAL RE-
2 QUIREMENT.—Beginning January 1, 2027, with
3 respect to an applicable imaging service fur-
4 nished in an applicable setting and paid for
5 under an applicable payment system (as defined
6 in subparagraph (D)), the furnishing profes-
7 sional shall include the national provider identi-
8 fier of the ordering professional (if different
9 from the furnishing professional) on the claim
10 for the service.

11 “(F) REPORTING REQUIREMENTS.—The
12 Secretary shall provide, through guidance or
13 rulemaking, information on appropriate ways
14 that each qualified clinical decision support
15 mechanism may report the information main-
16 tained under subparagraph (B) to the Secretary
17 to support the Secretary in implementing para-
18 graphs (5) and (6).”;

19 (3) in paragraph (5)—

20 (A) in the heading, by striking “OUTLIER”
21 and inserting “LOW COMPLIANT”;

22 (B) by striking subparagraphs (A) and (B)
23 and inserting the following:

24 “(A) IN GENERAL.—With respect to appli-
25 cable imaging services furnished on or after

1 January 1, 2027, the Secretary shall determine
2 on an annual basis the total number of ordering
3 professionals who are designated as low compli-
4 ant ordering professionals under subparagraph
5 (B).

6 “(B) LOW COMPLIANT ORDERING PROFES-
7 SIONALS.—The Secretary shall designate order-
8 ing professionals with a compliance rate (as de-
9 termined under subparagraph (D)) lower than
10 an amount determined by the Secretary as low
11 compliant ordering professionals.”;

12 (C) in paragraph (C), by striking “outlier”
13 and inserting “low compliant”;

14 (D) by striking subparagraph (D) and in-
15 serting the following:

16 “(D) DETERMINATION OF COMPLIANCE
17 RATE.—

18 “(i) IN GENERAL.—

19 “(I) COMPLIANCE RATES.—For
20 applicable imaging services furnished
21 on or after January 1, 2027, the Sec-
22 retary shall determine a compliance
23 rate (as defined in clause (ii)) for
24 each ordering professional for a period
25 specified by the Secretary.

1 “(II) USE OF DATA.—In deter-
2 mining a compliance rate for an or-
3 dering professional under subclause
4 (I), the Secretary shall use data made
5 available to the Secretary by qualified
6 clinical decision support mechanisms
7 published in the list under paragraph
8 (3)(C) that were consulted by the or-
9 dering professional for the period
10 specified by the Secretary under sub-
11 clause (I).

12 “(ii) DEFINITION OF COMPLIANCE
13 RATE.—

14 “(I) IN GENERAL.—In this sub-
15 paragraph, the term ‘compliance rate’
16 means, with respect to the require-
17 ment under paragraph (4)(A) that an
18 order from an ordering professional
19 for an applicable imaging service was
20 the subject of consultation with a
21 qualified decision support mechanism,
22 the ratio (expressed as a percentage)
23 of

24 “(aa) the number of orders
25 from such ordering professional

1 included in a report from one or
2 more qualified decision support
3 mechanisms described in para-
4 graph (3)(B); and

5 “(bb) the aggregate number
6 of such orders from such order-
7 ing professional for such period.

8 “(II) EXCLUSION OF EXCEPTED
9 ORDERS.—In calculating the compli-
10 ance rate for an ordering professional
11 under subclause (I), the Secretary
12 shall exclude from the total number of
13 orders in item (bb) of such subclause
14 any order for an applicable imaging
15 service described in paragraph
16 (4)(C).”; and

17 (E) in subparagraph (E), by striking
18 “outlier” and inserting “low compliant”;
19 (4) by striking paragraph (6) and inserting the
20 following:

21 “(6) STUDY AND REPORT ON LOW COMPLIANT
22 ORDERING PROFESSIONALS AND UTILIZATION OF AP-
23 PLICABLE IMAGING SERVICES.—

24 “(A) IN GENERAL.—Not later than Janu-
25 ary 1, 2031, and every 5 years thereafter, the

1 Secretary shall conduct a study regarding the
2 compliance rates calculated under paragraph
3 (5) and submit a report to Congress that—

4 “(i) discusses—

5 “(I) such rates and compliance
6 with this subsection;

7 “(II) the impact this subsection
8 has on the utilization of applicable im-
9 aging services; and

10 “(III) potential mechanisms for
11 improving compliance with this sub-
12 section, including—

13 “(aa) prior authorization for
14 applicable imaging services or-
15 dered by low compliant ordering
16 professionals;

17 “(bb) any payment adjust-
18 ment related to the services, or a
19 subset of services, that the Sec-
20 retary may designate under the
21 fee schedule under section 1848;
22 or

23 “(cc) other mechanisms de-
24 termined appropriate by the Sec-
25 retary; and

1 “(ii) proposes alternative compliance
2 rate thresholds for low compliant ordering
3 professionals for purposes of paragraph
4 (5)(B).”; and

5 (5) by adding at the end the following new
6 paragraph:

7 “(8) SPECIALTY SOCIETY ENDORSEMENT.—In
8 specifying applicable appropriate use criteria for ap-
9 plicable imaging services under paragraph (2) and
10 qualified clinical decision support mechanisms under
11 paragraph (3), the Secretary shall substantially ad-
12 here to the approach described in section 414.94 of
13 title 42, Code of Federal Regulations (as in effect on
14 January 1, 2023).”.

15 (b) EFFECTIVE DATE.—The amendments made by
16 subsection (a) shall apply with respect to items and serv-
17 ices furnished on or after January 1, 2027.

18 **SEC. 208. RULES OF CONSTRUCTION.**

19 (a) IN GENERAL.—None of the amendments made by
20 this title may be construed to—

21 (1) transfer ownership of a measure developed
22 by a qualified clinical data registry to the Secretary
23 or any other entity without the authorization of the
24 qualified clinical data registry; or

(2) require a qualified clinical data registry to
relinquish intellectual property rights as a condition
of having a measure considered for inclusion in the
annual final list of measures.

(b) IP.—The Secretary of Health and Human Services shall recognize that measures developed by qualified clinical data registries are the intellectual property of such registries, including any specifications, methodologies, scoring algorithms, specialty or subspecialty guidelines, and related materials associated with such measures. Nothing in this title shall prohibit a qualified clinical data from voluntarily licensing a measure to the Secretary or other entities under terms agreed to by such registry.

14 **TITLE III—APM IMPROVEMENT**

15 SEC. 301. QUALIFYING APM PARTICIPANT THRESHOLD
16 FREEZE.

17 (a) IN GENERAL.—Section 1833(z)(2) of the Social
18 Security Act (42 U.S.C. 1395l(z)(2)) is amended—

19 (1) in subparagraph (B)—

20 (A) in the header, by striking “2026 AND
21 2028” and inserting “2029”; and

(B) in the matter preceding clause (i), by striking “2026 and 2028” and inserting “2029”; and

25 (2) in subparagraph (C)—

1 (A) in the header, by striking “2027 AND
2 2029” and inserting “2030”; and

3 (B) in the matter preceding clause (i), by
4 striking “2027 and 2029” and inserting
5 “2030”.

6 (b) CONFORMING AMENDMENTS.—Section
7 1848(q)(1)(C)(iii) of the Social Security Act (42 U.S.C.
8 1395w–4(q)(1)(C)(iii)) is amended—

9 (1) in subclause (II), in the matter preceding
10 item (aa), by striking “2026 and 2028” and insert-
11 ing “2029”; and

12 (2) in subclause (III), the matter preceding
13 item (aa), by striking “2027 and 2029” and insert-
14 ing “2030”.

15 (c) AUTHORITY TO MODIFY THRESHOLDS.—Section
16 1848(q)(1)(C)(iii) of the Social Security Act (42 U.S.C.
17 1395w–4(q)(1)(C)(iii)) is amended—

18 (1) in subclause (II)—

19 (A) in item (aa), by inserting “(or such
20 lower percentage as may be specified by the
21 Secretary)” after “40 percent”; and

22 (B) in item (bb), by inserting “(or such
23 lower percentages as may be specified by the
24 Secretary)” after “respectively”; and

25 (2) in subclause (III)—

1 (A) in item (aa), by inserting “(or such
2 lower percentage as may be specified by the
3 Secretary)” after “50 percent”; and

4 (B) in item (bb), by inserting “(or such
5 lower percentages as may be specified by the
6 Secretary)” after “respectively”.

7 **SEC. 302. CMI MODEL REQUIREMENTS.**

8 Section 1115A of the Social Security Act (42 U.S.C.
9 1315a) is amended—

10 (1) in subsection (b)(3)(B), by inserting “, pur-
11 suant to notice-and-comment rulemaking,” after
12 “The Secretary shall”;

13 (2) in subsection (c), in the flush matter at the
14 end, by adding at the end the following new sen-
15 tence: “The Secretary may terminate a model ex-
16 panded under this subsection prior to the date set
17 for such termination at the time of such expansion
18 only pursuant to notice and comment rulemaking.”;
19 and

20 (3) in subsection (g), by adding at the end the
21 following new sentence: “Each such report submitted
22 in 2027 or a subsequent year shall contain, with re-
23 spect to each model tested under subsection (b), a
24 description of any savings generated by such
25 model.”.

1 **SEC. 303. REPORT ON BARRIERS TO PARTICIPATION IN**
2 **VALUE-BASED PAYMENT MODELS.**

3 Not later than December 31, 2029, the Comptroller
4 General of the United States, in consultation with the
5 Medicare Payment Advisory Commission, shall submit to
6 the Committees on Energy and Commerce and Ways and
7 Means of the House of Representatives, and the Com-
8 mittee on Finance of the Senate, a report on ongoing bar-
9 riers to participation in value-based payment models for
10 specialty providers under the Medicare program. Such re-
11 port shall contain specific policy recommendations to re-
12 duce such barriers.

13 **TITLE IV—PHYSICIAN PAYMENT**
14 **IMPROVEMENTS**

15 **SEC. 401. UPDATING THE BUDGET NEUTRALITY THRESH-**
16 **OLD.**

17 Section 1848(c)(2)(B)(ii)(II) of the Social Security
18 Act (42 U.S.C. 1395w-4(c)(2)(B)(ii)(II)) is amended—

19 (1) by striking “Subject to” and inserting the
20 following:

21 “(aa) IN GENERAL.—Sub-
22 ject to”;

23 (2) in item (aa), as inserted by paragraph (1),
24 by striking “\$20,000,000” and inserting “the
25 amount specified in item (bb) for such year”; and

1 (3) by adding at the end the following new
2 items:

3 “(bb) AMOUNT SPECI-
4 FIED.—For purposes of item
5 (aa), subject to item (cc), the
6 amount specified in this item
7 is—

8 “(AA) for years before
9 2028, \$20,000,000;

10 “(BB) for 2028,
11 \$57,640,000; and

12 “(CC) for 2029 and
13 each subsequent year, the
14 amount specified in this
15 item for the preceding year.

16 “(cc) INDEXING LIMITATION
17 ON ANNUAL ADJUSTMENTS.—For
18 2033 and every subsequent fifth
19 year, the Secretary shall increase
20 the amount specified in item (bb)
21 for such year by the cumulative
22 percentage increase in the MEI
23 (as defined in section 1842(i)(3))
24 applicable to physicians’ services
25 for each year occurring during

1 the 5-year period ending on the
2 last day of the preceding year.”.

3 **SEC. 402. BUDGET NEUTRALITY CORRECTIONS RELATING**
4 **TO ESTIMATED UTILIZATION.**

5 (a) IN GENERAL.—Section 1848(c)(2)(B) of the So-
6 cial Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amend-
7 ed by adding at the end the following new clause:

8 “(vii) BUDGET NEUTRALITY CORREC-
9 TIONS RELATING TO ESTIMATED UTILIZA-
10 TION.—

11 “(I) IN GENERAL.—In the case
12 of a budget neutrality adjustment ap-
13 plied pursuant to clause (ii)(II) for a
14 year (beginning with 2029) that is de-
15 termined in part using estimated utili-
16 zation (as defined in subclause
17 (II)(bb)) with respect to a specified
18 service (as defined in subclause
19 (II)(cc)), the Secretary shall, as part
20 of the final rule establishing the phy-
21 sician fee schedule under this section
22 for the assumption correction period
23 (as defined in subclause (II)(aa)) with
24 respect to such year—

1 “(aa) determine the dif-
2 ference between expenditures for
3 such service in such year using
4 estimated utilization and actual
5 utilization for such service (in a
6 manner determined appropriate
7 by the Secretary); and

8 “(bb) in the case that the
9 Secretary determines the dif-
10 ference described in item (aa) is
11 greater than the threshold
12 amount (as defined in subclause
13 (II)(dd)) for such year, adjust
14 the conversion factor under this
15 section for such assumption cor-
16 rection period by such amount to
17 reconcile such difference (which
18 may be positive or negative), as
19 determined by the Secretary.

20 “(II) DEFINITIONS.—For pur-
21 poses of this clause:

22 “(aa) ASSUMPTION CORREC-
23 TION PERIOD.—The term ‘as-
24 sumption correction period’
25 means, with respect to a year,

1 the second year beginning after
2 such year.

3 “(bb) ESTIMATED UTILIZA-
4 TION.—The term ‘estimated utili-
5 zation’ means an estimate of uti-
6 lization used for purposes of ap-
7 plying clause (ii)(II).

8 “(cc) SPECIFIED SERVICE.—
9 The term ‘specified service’
10 means, with respect to a year, a
11 service—

12 “(AA) with expected ex-
13 penditures for such year
14 under this section based on
15 estimated utilization that ex-
16 ceed the threshold amount
17 (as defined in item (dd)) for
18 such year; and

19 “(BB) for which pay-
20 ment had been bundled into
21 payment for another service
22 during the preceding year
23 and for which a separate
24 payment or add-on payment
25 is made during such year.

1 “(dd) THRESHOLD
2 AMOUNT.—The term ‘threshold
3 amount’ means, with respect to a
4 year, 0.1 percent of the total esti-
5 mated expenditures under this
6 part for services furnished under
7 this section during such year.”.

8 (b) NONAPPLICATION OF BUDGET NEUTRALITY TO
9 RECONCILIATION ADJUSTMENTS.—Section 1848(c)(2)(B)
10 of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B))
11 is amended—

12 (1) in clause (iv)—

13 (A) in subclause (V), by striking “and” at
14 the end;

15 (B) in subclause (VI), by striking the pe-
16 riod and inserting “; and”; and

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

19 “(VII) clause (vii)(I)(bb) for an
20 assumption correction period (as de-
21 fined in clause (vii)(II)) shall not be
22 taken into account in applying clause
23 (ii)(II) with respect to such period.”;
24 and

1 (2) in clause (v), by adding at the end the fol-
2 lowing new subclause:

3 “(XII) REDUCTIONS ATTRIB-
4 UTABLE TO AN ASSUMPTION CORREC-
5 TION.—For an assumption correction
6 period (as defined in clause (vii)(II)),
7 reduced expenditures attributable to
8 application of clause (vii)(I)(bb) with
9 respect to such period.”.

10 **SEC. 403. TIMELY UPDATES TO DIRECT COSTS USED TO**
11 **CALCULATE PRACTICE EXPENSE RVUS.**

12 Section 1848(c)(2)(B) of the Social Security Act (42
13 U.S.C. 1395w–4(c)(2)(B)), as amended by section 3, is
14 further amended by adding at the end the following new
15 clause:

16 “(viii) TIMELY UPDATES TO DIRECT
17 COSTS USED TO CALCULATE PRACTICE EX-
18 PENSE RELATIVE VALUE UNITS.—

19 “(I) SIMULTANEOUS UPDATES TO
20 DIRECT COST INPUTS AT LEAST ONCE
21 EVERY 5 YEARS.—The Secretary shall,
22 not less often than every 5 years, up-
23 date the prices and rates, as applica-
24 ble, on a category-wide basis for each
25 of the categories of direct cost inputs

1 described in subclause (II) used in the
2 methodology for calculating the prac-
3 tice expense relative value units under
4 this subsection for physicians' serv-
5 ices. Updates made pursuant to the
6 previous sentence shall be made in the
7 same year for all categories of direct
8 cost inputs described in such sub-
9 clause.

10 “(II) DIRECT COST INPUTS CAT-
11 EGORIES DESCRIBED.—For purposes
12 of this clause, the categories of direct
13 cost inputs described in this subclause
14 are clinical staff wage rates, prices of
15 medical supplies, prices of equipment,
16 and any other category of such inputs
17 used in the methodology described in
18 subclause (I) (as specified by the Sec-
19 retary).

20 “(III) CONSULTATION.—In mak-
21 ing the updates under this clause, the
22 Secretary shall consult with relevant
23 stakeholders, including physician spe-
24 cialty societies.”.

1 **SEC. 404. LIMITATION ON YEAR-TO-YEAR CONVERSION FAC-**
2 **TOR VARIANCE.**

3 Section 1848(c)(2)(B) of the Social Security Act (42
4 U.S.C. 1395w-4(c)(2)(B)), as amended by sections 3 and
5 4, is further amended by adding at the end the following
6 new clause:

7 “(ix) LIMITATION ON CONVERSION
8 FACTOR VARIANCE.—

9 “(I) IN GENERAL.—Beginning
10 with 2027, the Secretary may not, for
11 purposes of complying with clause
12 (ii)(II), apply a budget neutrality ad-
13 justment to a conversion factor estab-
14 lished under subsection (d) for such
15 year that would cause such factor, not
16 taking into account any adjustment to
17 such factor for such year provided
18 under such subsection, to vary by
19 more than 2.5 percent compared to
20 such factor so established for the pre-
21 ceding year.

22 “(II) CONTINUED APPLICABILITY
23 OF BUDGET NEUTRALITY REQUIRE-
24 MENT.—Nothing in subclause (I) may
25 be construed to alter the requirement
26 described in clause (ii)(II).”.