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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Patients First Act of 2026''.

TITLE I—STRENGTHENING REIMBURSEMENT AND PATIENT ACCESS

SEC. 101. MODIFYING THE CONVERSION FACTOR UPDATES APPLICABLE TO PHYSICIANS' SERVICES UNDER THE MEDICARE PROGRAM.

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

(1) in paragraph (1)(A), in the second sentence, by inserting ''or (21)'' after ''paragraph (20)'';

(2) in paragraph (20)—

(A) in the header, by striking ''AND SUBSEQUENT YEARS''; and

(B) by striking ''and each subsequent year''; and

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

''(21) UPDATE FOR 2027 AND SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For 2027 and each subsequent year, the update to the nonqualifying APM conversion factor established under paragraph (1)(A) is, subject to subparagraph (B), the Secretary's estimate of the percentage increase in the MEI (as defined in section

1842(i)(3)) for the year, less 1 percentage point, and the update to the qualifying APM conversion factor established under such paragraph is the update to the nonqualifying APM conversion factor for the year, increased by 0.5 percentage point.

''(B) FLOOR AND CEILING ON NONQUALIFYING APM CONVERSION FACTOR UPDATE.—In the case that the update to the nonqualifying APM conversion factor for a year as calculated under subparagraph (A) is—

''(i) less than 25 percent of the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year, such update shall be deemed to be equal to 25 percent of such estimate; or

''(ii) more than 75 percent of such estimate, such update shall be deemed to be equal to 75 percent of such estimate.''.

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

U.S.C. 1395w–4(d)) for such year. Such report shall include an analysis of the impact of such updates on Medicare beneficiaries' access to services under the Medicare program and on the consolidation of physician practices.

SEC. 102. HYBRID PAYMENT MODEL FOR PRIMARY CARE SERVICES.

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

"SEC. 1866H. HYBRID PAYMENT MODEL FOR PRIMARY CARE SERVICES.

''(a) IN GENERAL.—The Secretary shall, for 2027 and each subsequent year through 2031, carry out a hybrid payment model for primary care services (in this section referred to as the 'model') under which the Secretary shall make a monthly payment to each qualifying supplier for each individual attributed to such practice for such year in lieu of payment for any designated primary care services furnished by such supplier to such individuals during such year that would otherwise be made under the payment schedule established under section 1848 (or on the basis of such schedule).

''(b) PAYMENT AMOUNT.—

''(1) IN GENERAL.—The monthly amount payable to a qualifying supplier for a year under the

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

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

''(c) ATTRIBUTION PROCESS.—

''(1) IN GENERAL.—The Secretary shall establish a process under which, for each year of the model, individuals enrolled under part B who are not enrolled under an MA plan under part C may designate a qualifying supplier as such individual's primary care provider for such year.

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

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

''(3) TREATED AS ATTRIBUTED.—For purposes of this section, each individual who makes a designation under paragraph (1) (or for whom such a designation is made under paragraph (2)) with respect to a qualifying supplier for a year shall be treated as attributed to such supplier for such year.

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

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

''(f) DEFINITIONS.—In this section:

''(1) DESIGNATED HEALTH CARE PRACTITIONER.—The term 'designated health care practitioner' means a physician assistant, a nurse practitioner, a clinical nurse specialist, a physical therapist, an occupational therapist, or such other health care practitioner as the Secretary may specify.

''(2) DESIGNATED PRIMARY CARE SERVICES.—The term 'designated primary care services' means—

''(A) care management services;

''(B) behavioral health integration services;

''(C) office-based evaluation and management services (whether furnished in person or via telehealth); and

''(D) communications such as telephone calls, emails and patient portals between patients and their care givers.

''(3) EXCLUDED PRACTICE.—

''(A) IN GENERAL.—The term 'excluded practice' means, subject to subparagraph (B), any practice—

''(i) in which any entity that is not a physician or designated health care practitioner or a professional corporation, professional association, limited liability company, or other professional body that is majority owned and controlled by physicians or designated health care practitioners has an ownership interest;

''(ii) in which any entity described in subparagraph (A) exercises de facto con-

trol over employment decisions (including rates of pay and terms of employment), clinical staffing levels, amount of time spent between a supplier and a patient, diagnostic or procedural coding decisions, clinical standards or policy, billing and collection, prices for items and services, contracting with third party payors, or controlling or restricting the practice's assets;

''(iii) in which physicians or designated health care practitioners hold 50 percent or less of voting shares or membership interests;

''(iv) that has a governing board in which physicians or designated health care practitioners constitute less than 50 percent of the members; or

''(v) in the case such practice is a corporation or professional association, that permits the removal of directors or officers that are physicians or designated health care practitioners except by majority vote of stakeholders that are physicians or designated health care practitioners.

"(B) EXCEPTION.—The term 'excluded practice' does not include any practice consisting of 15 or fewer designated health care practitioners.

"(4) SPECIFIED PRACTITIONER.—The term 'specified practitioner' means—

"(A) a physician with a primary specialty or practice area of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

"(B) a physician assistant, a nurse practitioner, or a clinical nurse specialist.

"(5) QUALIFYING SUPPLIER.—The term 'qualifying supplier' means, with respect to a year, a specified practitioner—

"(A) who is not part of an excluded practice;

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

"(C) for whom, with respect to payments under this title for all items and services furnished by such practitioner during the preceding year, at least 60 percent of such payments were for designated primary care services; and

''(D) who has elected to participate in the model for such year through such process as the Secretary shall establish.''.

SEC. 103. WORK GEOGRAPHIC FLOOR ADJUSTMENT FOR HIGH INFLATIONARY YEARS.

(a) IN GENERAL.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended—

(1) by striking the header and inserting ''WORK GEOGRAPHIC INDEX'';

(2) by striking ''After calculating'' and inserting the following:

''(i) IN GENERAL.—After calculating'';

(3) in clause (i) (as so inserted)—

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

(B) by striking ''2027'' and inserting ''2032''; and

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

''(ii) INCREASE IN HIGH INFLATIONARY YEARS FOR OTHER LOCALITIES.—After calculating the work geographic index in subparagraph (A)(iii), for

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

''(iii) DEFINITION.—In this subparagraph, the term 'high inflationary year' means a year if, over the 12-month period ending on the last day of the preceding year, the consumer price index for all urban consumers (U.S. city average) increased by more than 2 percent.

''(iv) PUBLICATION.—Medicare administrative contractors shall publish the geographically adjusted work relative value units for both the inflation adjustments under clauses (i) and (ii) and the work geographic adjustment for all services on a quarterly basis effective January 1, 2027, for each of their geographic areas.''.

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

United States shall submit to the House Energy and Commerce and Ways and Means Committees and Senate Finance Committee a study on the economic factors that are impacting physician choice, by specialty, regarding the geographic area in which such physicians choose to practice, including salaries, contract terms, cost of living, availability of capital, volume of services, and costs to conduct a practice.

TITLE II—POINTS

SEC. 201. IMPLEMENTATION OF THE PATIENT OUTCOME IMPROVEMENT NATIONAL TABULATION SYSTEM.

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

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

(c) TRANSITION.—In order to provide for an orderly transition and avoid provider confusion, the Secretary of Health and Human Services shall provide for an appropriate transition in the use of the terms ''Merit-based Incentive Payment System'' (and ''MIPS'') and ''Patient Outcome Improvement National Tabulation System'' (and ''POINTS'') in reference to the payment system under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)). Before the completion of such transition, any reference to the ''Patient Outcome Improvement National Tabulation System'' (or ''POINTS'') shall be deemed to include a reference to the ''Merit-based Incentive Payment System''.

SEC. 202. PAYMENT REFORM.

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

(1) in paragraph (1)(D)(i)(II), by striking ''(iv)'' and inserting ''(v)'';

(2) in paragraph (2)—

(A) in subparagraph (A)—

(i) in clause (iii), by striking ''Clinical practice'' and inserting ''For performance periods beginning before January 1, 2032, clinical practice'';

(ii) in clause (iv), by striking ''Meaningful use'' and inserting ''For performance periods before January 1, 2032, meaningful use''; and

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

''(v) For performance periods beginning on or after January 1, 2032, care efficiency.'';

(B) in subparagraph (B)—

(i) in clause (ii)—

(I) by striking ''subparagraph (A)(ii), the measurement'' and inserting the following: ''subparagraph (A)(ii)—

''(I) for performance periods beginning before January 1, 2032, the measurement''; and

(II) by striking the period at the end and inserting the following: ''; and

''(II) for performance periods beginning on or after January 1, 2032, the measurement described in subclause (I) and any resource use meas-

ures included in the final measures list published under subparagraph (D)(i) for such period.''; and

(ii) by inserting after clause (iv) the following new clause:

''(v) CARE EFFICIENCY.—For the performance category described in subparagraph (A)(v), care efficiency measures (such as measures relating to reductions in avoidable hospitalizations, reductions in medication burden (when clinically appropriate), reductions in complications from chronic diseases, and referral patterns to the lowest-cost clinically appropriate settings) included in the final measures list published under subparagraph (D)(i) for such period.'';

(C) in subparagraph (D)—

(i) in the header, by striking ''QUALITY'';

(ii) in clause (i)—

(I) in the matter preceding subclause (I), by inserting ''(or, with respect to performance periods beginning on or after January 1, 2032, an

annual final list of quality measures, resource use measures (if determined appropriate by the Secretary), and care efficiency measures)'' after ''quality measures''; and

(II) in subclause (II)—

(aa) in item (aa), by striking ''quality measures'' and inserting ''measures'';

(bb) in item (bb), by inserting ''(or, with respect to a final list for a performance period beginning on or after January 1, 2032, new quality measures, resource use measures, or care efficiency measures)'' after ''quality measures''; and

(cc) in item (cc), by striking ''quality measures'' and inserting ''measures'';

(iii) in clause (ii)—

(I) in the header, by striking ''quality''; and

(II) in subclause (I)—

(aa) by inserting ''(or, with respect to such an annual list for a performance period beginning on or after January 1, 2032, quality measures, resource use measures, and care efficiency measures)'' after ''submit quality measures''; and

(bb) by striking ''quality measures published'' and inserting ''measures published'';

(iv) in clause (iii)—

(I) in the matter preceding subclause (I), by striking ''quality'';

(II) in subclause (I), by striking ''and'' at the end;

(III) in subclause (II)—

(aa) by striking ''ensure that'' and inserting ''with respect to such an annual final list for a performance period beginning before January 1, 2032, ensure that''; and

(bb) by striking the period at the end and inserting ''; and''; and

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

''(III) with respect to such an annual final list for a performance period beginning on or after January 1, 2032, provide that—

''(aa) no quality measure applicable to a medical specialty is included on such list if—

''(AA) the task force established under subparagraph (E) has issued recommendations on quality measures for use under this subsection with respect to such specialty; and

''(BB) the quality measure does not have in effect such a recommendation; and

''(bb) no resource use measure or care efficiency measure is

included on such list unless such measure has in effect a recommendation from such task force.'';

(v) in clause (v), in the matter preceding subclause (I), by inserting ''for a performance period beginning before January 1, 2032,'' after ''published under clause (i)'';

(vi) in clause (vi), by striking ''under clauses (i), (iv), and (v)'' and inserting ''under this subparagraph''; and

(vii) in clause (vii)(II), by striking ''shall be'' and inserting ''subject to clause (iii)(III)(aa), shall be'';

(3) in paragraph (5)—

(A) in subparagraph (B)—

(i) in clause (ii)—

(I) in subclause (I)—

(aa) by striking ''encourage'' and inserting ''with respect to a performance period beginning before January 1, 2032, encourage''; and

(bb) by striking ''and'' at the end;

(II) in subclause (II), by striking the period and inserting ''; and''; and

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

''(III) with respect to a performance period beginning on or after January 1, 2032, with respect to a year, provide that in the case of a MIPS eligible professional who fails to report on an applicable quality measure through the use of certified EHR technology or clinical data registries, the professional shall be treated as achieving the lowest potential score applicable to such measure.''; and

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

''(iii) INCENTIVE TO REPORT ON CERTAIN MEASURES.—

''(I) IN GENERAL.—With respect to performance periods for years beginning on or after January 1, 2027, in the case a MIPS eligible profes-

sional elects to report on a measure for such period that, with respect to such professional and such period, is a new measure described in subclause (II), a substantively changed measure described in subclause (III), or a measure described in paragraph (2)(B)(i) for which the Secretary is unable to establish a benchmark, such professional shall be treated as achieving the highest possible score with respect to such measure.

''(II) NEW MEASURES.—For purposes of subclause (I), a new measure described in this subclause, with respect to a MIPS eligible professional and performance period for a year, is a measure applicable to such professional with respect to the performance category described in paragraph (2)(A)(i) that is included in the final list of quality measures published under paragraph (2)(D)(i) (or the list of quality measures described in paragraph (2)(D)(vi) used by qualified

clinical data registries under subsection (m)(3)(E)) for such year but was not included in such final list under paragraph (2)(D)(i) (or list under paragraph (2)(D)(vi)) for any of the previous 3 years.

''(III) SUBSTANTIVELY CHANGED MEASURE.—For purposes of subclause (I), a substantively changed measure described in this subclause, with respect to a MIPS eligible professional and performance period for a year, is a measure applicable to such professional with respect to the performance category described in paragraph (2)(A)(i) that is included in the final list of quality measures published under paragraph (2)(D)(i) (or the list of quality measures described in paragraph (2)(D)(vi) used by qualified clinical data registries under subsection (m)(3)(E)) for such year and each of the previous three years but that underwent a substantive change (as defined by the Secretary) during

any of such previous three years.''; and

(B) in subparagraph (E)—

(i) in clause (i)—

(I) in subclause (I)(aa), by inserting ''(or, with respect to 2032 and subsequent years, 65 percent)'' after ''thirty percent'';

(II) in subclause (II)(aa), by inserting ''(or, with respect to 2032 and subsequent years, 20 percent)'' after ''thirty percent'';

(III) in subclause (III), by inserting ''(or, with respect to 2032 and subsequent years, 0 percent)'' after ''fifteen percent'';

(IV) in subclause (IV), by inserting ''(or, with respect to 2032 and subsequent years, 0 percent)'' after ''twenty-five percent''; and

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

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

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

(ii) in clause (ii), by inserting ''(before 2032)'' after ''In any year'';

(4) in paragraph (11)(A)(i), by striking ''clauses (i) through (iv) of''; and

(5) in paragraph (12)(A)(i)(II), by striking ''and (iv)'' and inserting ''through (v)''.

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

(1) in paragraph (2)(H), by adding at the end the following new sentence: ''In making such revisions for 2027 and subsequent years, the Secretary shall revise care episode groups and patient condition groups without regard to any target described in subparagraph (D)(i)(I).''; and

(2) in paragraph (5)(C)(i)—

(A) by inserting '', for years before 2027,'' after ''shall''; and

(B) by inserting ''and shall, for 2027 and subsequent years, use such care episode codes and patient condition codes'' before the period.

SEC. 203. QUALITY REFORM TASK FORCE.

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

"(E) QUALITY REFORM TASK FORCE.—

"(i) IN GENERAL.—Not later than 6 months after the date of the enactment of this subparagraph, the Secretary shall establish a Quality Reform Task Force (in this subparagraph referred to as the 'Task Force') for purposes of issuing recommendations with respect to the use of quality, resource use, and care efficiency measures under this subsection.

"(ii) MEMBERSHIP.—

"(I) IN GENERAL.—Members of the Task Force shall be appointed by the Secretary and shall include—

"(aa) representatives of the Department of Health and Human Services;

"(bb) representatives of eligible professional organizations (as defined in subparagraph (D)(ii)(II)); and

"(cc) other experts determined appropriate by the Secretary.

"(II) APPROPRIATE REPRESENTATION.—In making appointments under subclause (I), the Secretary shall ensure that—

"(aa) each medical specialty or subspecialty as determined appropriate by the Secretary in which a MIPS eligible professional may practice is adequately represented on the Task Force through a relevant organization described in subclause (I)(bb) if a measure relating to such specialty or subspecialty is under consideration;

"(bb) a majority of the Task Force is comprised of designated health care practitioners (as defined in section 1866H(f)) or representatives of designated health care professional-led pro-

fessional organizations described in subclause (I)(bb);

"(cc) not more than 3 members of the Task Force are representatives of group health plans, health insurance issuers, or Medicare Advantage organizations; and

"(dd) at least 1 designated health care practitioner who is not part of an excluded practice (as defined in section 1866H(f)) who practices in a medical specialty or subspecialty is included on the Task Force when the Task Force is considering measures relating to such specialty or subspecialty.

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

"(iii) DUTIES.—

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

formance period beginning on or after January 1, 2032—

"(aa) issue recommendations on quality, resource use, and care efficiency measures for use under this subsection; and

"(bb) update any recommendations previously issued by the Task Force as determined appropriate by the Task Force.

"(II) REQUIREMENTS.—The Task Force—

"(aa) shall ensure that any measure recommended under subclause (I) conforms with applicable clinical guidelines developed by a professional organization representing the medical specialty or subspecialty to be subject to such measure and is designed to promote quality of care, improve resource use, or reduce costs;

"(bb) may only recommend a quality measure to the extent

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

''(cc) shall take into account the circumstances of practitioners in specialty types that furnish services that do not typically involve face-to-face interaction with patients (or that typically involve such interaction only at the direction of another practitioner ordering such services);

''(dd) shall, in reviewing measures and making recommendations, take into account—

''(AA) how the measure relates to an episode of care or a continuum of health care, as applicable, involved;

''(BB) the context of the respective performance category of such measure

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

''(CC) measures developed by qualified clinical data registries; and

''(DD) consult with such registries as necessary in the development and evaluation of measures; and

''(ee) ensure that the role of qualified clinical data registries in the development, maintenance, and refinement of measures is preserved or strengthened.

''(iv) SECRETARIAL RESPONSE TO RECOMMENDATIONS.—

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

Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a formal written response that, with respect to each such recommendation, affirmatively states one of the following:

''(aa) The Secretary will implement the recommendation as issued.

''(bb) The Secretary will implement the recommendation with specified modifications, accompanied by a written explanation of the modifications and the clinical, administrative, or program integrity basis for each such modification.

''(cc) The Secretary will implement the recommendation in part, accompanied by a written explanation of which elements will be implemented and the basis for declining the remainder.

"(dd) The Secretary declines to implement the recommendation, accompanied by a detailed written explanation of the clinical, administrative, or program integrity basis for the decision.

"(II) INCLUSION OF MEASURES.—

"(aa) IN GENERAL.—The Secretary shall include a measure receiving a recommendation from the Task Force for a performance period in the final measures list published under subparagraph (D)(i) for such performance period unless the Secretary, not later than 90 days after receiving the recommendation, publishes in the Federal Register a written determination explaining the specific clinical, administrative, or program integrity basis for excluding the measure.

"(bb) FURTHER REQUIREMENTS FOR CERTAIN REC-

OMMENDATIONS.—Notwithstanding item (aa), with respect to any measure recommended by the Task Force for a performance period with the support of not fewer than 75 percent of the members of the Task Force, the Secretary may not exclude such measure from the final measures list published under subparagraph (D)(i) for such performance period unless the Secretary—

''(AA) consults with the task force regarding such proposed exclusion; and

''(BB) includes in the written determination under subclause (I) a response to the Task Force's position and a specific finding that the basis for exclusion outweighs the clinical judgment of the Task Force.

''(III) ANNUAL REPORT.—Not later than March 1 of each year beginning with the first calendar year after the Task Force issues its initial recommendations, the Secretary shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate, and shall make publicly available on the website of the Centers for Medicare & Medicaid Services, a report that includes, for each recommendation issued by the Task Force during the preceding calendar year—

''(aa) the text of the recommendation and the vote of the Task Force;

''(bb) the Secretary's response under subclause (I);

''(cc) the outcome with respect to the final measures list published under subparagraph (D)(i), including whether the rec-

ommended measure was included, included with modifications, or excluded; and

''(dd) if the measure was excluded or modified, the written justification provided under subclause (I).''.

SEC. 204. MODIFICATION OF MIPS PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—Section 1848(q)(6)(B) of the Social Security Act (42 U.S.C. 1395w–4(q)(6)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

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

''(iv) for 2022 and subsequent years (through 2031), 9 percent;''; and

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

''(v) for 2032, 3 percent;

''(vi) for 2033, 4 percent; and

''(vii) for 2034, 5 percent.''.

(b) NO REDUCTION IN CASE OF FAILURE TO PROVIDE FEEDBACK.—

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

"(G) NO REDUCTION IN PAYMENTS IN CASE OF FAILURE TO PROVIDE FEEDBACK.—Notwithstanding the preceding provisions of this paragraph, in the case that the Secretary fails to provide a MIPS eligible professional feedback required under paragraph (12) with respect to the performance of such professional for a performance period with respect to a year for administrative claims-based measures included in the performance categories described in subparagraph (A)(i)(II) of such paragraph, if application of subparagraph (E) would result in a negative adjustment to payment for covered professional services furnished by such professional during such year, the product otherwise determined under such subparagraph for such professional and year shall be deemed to be zero.".

(2) MODIFICATION OF FEEDBACK REQUIREMENTS.—Section 1848(q)(12) of the Social Security Act (42 U.S.C. 1395w–4(q)(12)) is amended—

(A) in subparagraph (A)(i)(II), by inserting ''(and, beginning with 2032, shall, on a quarterly basis and with respect to administrative claims-based measures in accordance with clause (vi))'' after ''may''; and

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

''(vi) FEEDBACK ON ADMINISTRATIVE-CLAIMS BASED MEASURES.—With respect to quarters beginning on or after January 1, 2032, the Secretary shall, not later than 60 days after each such quarter, provide to each MIPS eligible professional, with respect administrative claims-based measures included in the performance categories described in subparagraph (A)(i)(II), feedback on such professional's performance, including—

''(I) a description of the patients and episodes attributed with respect to such measures for purposes of assessing the performance of such professional during such quarter;

''(II) an identification of the items and services furnished by such

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

''(III) an identification of whether each item or service identified under subitem (BB) for the quarter was furnished by such professional or another individual (and, in the case that the performance of such professional for such quarter with respect to such measures is assessed based on participation in a group practice or other group, whether each such item or service was furnished by such professional, another individual in such group, or another individual outside of such group).''.

(c) EXTENSION OF ADDITIONAL INCENTIVE PAYMENTS FOR CERTAIN PROFESSIONALS.—Section 1848(q)(6) of the Social Security Act (42 U.S.C. 1395w–4(q)(6)) is amended—

(1) in subparagraph (C)—

(A) by inserting ''and for 2032 and each subsequent year'' after ''2024,''; and

(B) by inserting ''(other than, with respect to 2032 and each subsequent year, such a professional that is part of an excluded practice (as defined in section 1866H(f)))'' after ''MIPS eligible professional''; and

(2) in subparagraph (F)(iv)(I), by inserting ''and for 2032 and each subsequent year'' before the period.

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

''(H) REDUCTION IN POSITIVE ADJUSTMENTS FOR CERTAIN PROFESSIONALS.—The Secretary shall reduce each positive MIPS adjustment factor otherwise determined under this paragraph for a year (beginning with 2032) for a MIPS eligible professional who is part of an excluded practice (as defined in section 1866H(f)) by 50 percent. The preceding sentence shall be applied in a budget neutral manner.''.

SEC. 205. MODIFYING REQUIREMENTS AND APPROVAL PERIODS FOR QUALIFIED CLINICAL DATA REGISTRIES.

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

(1) in clause (i), by adding at the end the following: ''Beginning January 1, 2027, such requirements shall include a requirement that the entity—

''(I) be established and operated by a professional society that is controlled or led by a designated practitioner (as defined in section 1866H) and that has demonstrated expertise in developing evidence-based clinical practice guidelines and quality measures for improving patient outcomes;

''(II) demonstrates adherence to data quality and fidelity standards, including standards relating to data elements, data completeness, and validation processes;

''(III) demonstrates capacity to generate timely, actionable feedback to participating practitioners to support continuous quality improvement

and track practitioner use of such feedback;

''(IV) demonstrate transparency in measure development (including the methodology used in such measures and any risk adjustment used in such measures); and

''(V) has established self-audit or review processes focusing on data accuracy, measure integrity, and appropriate use of results.''; and

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

''A determination or designation made under this clause on or after January 1, 2027, shall be effective for a period of 3 years. At the end of such period, the Secretary (or, in the case of a designation made by an organization, such organization) may extend such determination or designation (as applicable) for subsequent 3-year periods based on a showing by such entity that such entity continues to meet the requirements of clause (i).''.

SEC. 206. EXPANDED ACCESS TO CLAIMS DATA TO FACILITATE RESEARCH AND QUALITY IMPROVEMENT.

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

(1) linking such data with clinical outcomes data;

(2) conducting quality assessments and quality improvement activities of providers of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x) and suppliers (as defined in subsection (d) of such section)), reporting the results of such assessments and activities to such providers and suppliers, and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety; and

(3) publishing research and quality improvement analyses, which may include deidentified combined claims and clinical outcomes data.

(b) CLAIMS DATA DESCRIBED.—For purposes of subsection (a), the claims data described in this subsection—

(1) are—

(A) claims data under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(B) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) and the State Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.); and

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

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

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

(d) FEE.—Data described in subsection (b) shall be made available to a qualified clinical data registry or clinician-led clinical data registry under this section at a reasonable fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Centers for Medicare & Medicaid Services Program Management Account.

SEC. 207. MODIFICATION OF APPROPRIATE USE CRITERIA DATA COLLECTION FOR APPLICABLE IMAGING SERVICES.

(a) IN GENERAL.—Section 1834(q) of the Social Security Act (42 U.S.C. 1395m(q)) is amended—

(1) in paragraph (3)(B)(ii)—

(A) in subclause (IV), by striking ''generates and provides to the ordering professional a certification or documentation that''; and

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

''(VIII) Beginning January 1, 2027, the mechanism provides to the Secretary—

''(aa) the information described in subclauses (III) and (IV);

''(bb) the information described in paragraph (4)(B); and

''(cc) such other information as the Secretary determines to be appropriate, at such time, and in such form and manner, as the Secretary may specify.'';

(2) in paragraph (4)—

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

''(ii) beginning January 1, 2027, comply with such requirements as the Secretary may establish.'';

(B) in subparagraph (B)—

(i) in the heading, by striking ''FURNISHING PROFESSIONAL'' and inserting ''QUALIFIED CLINICAL DECISION SUPPORT MECHANISM'';

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

(I) by striking ''with January 1, 2017'' and inserting ''January 1, 2027''; and

(II) by striking ''payment for such service may only be made if the claim for the service includes'' and inserting ''the qualified decision support mechanism shall maintain and report to the Secretary under subparagraph (F)''; and

(iii) in clause (iii), by striking ''(if different from the furnishing professional)'';

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

''(iv) CLINICAL TRIALS.—An applicable imaging service that is ordered for an individual as part of a clinical trial.

''(v) SMALL AND RURAL PRACTICES.—An applicable imaging service ordered by an ordering professional practicing in a small practice (consisting of 15 or fewer ordering professionals), or a practice in a health professional shortage area (as designated under section 332(a)(1)(A)

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

''(vi) SPECIFIED EXEMPTIONS.—The following types of applicable imaging services:

''(I) A mammography.

''(II) A lung cancer screening performed using computed tomography.

''(III) A colonography performed using computed tomography.

''(IV) Such a service furnished to treat an emergency medical condition or a suspected emergency medical condition.

''(V) Such other preventive or screening imaging services as the Secretary determines appropriate.'';

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

''(iv) Any other payment system determined appropriate by the Secretary.''; and

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

''(E) FURNISHING PROFESSIONAL REQUIREMENT.—Beginning January 1, 2027, with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), the furnishing professional shall include the national provider identifier of the ordering professional (if different from the furnishing professional) on the claim for the service.

''(F) REPORTING REQUIREMENTS.—The Secretary shall provide, through guidance or rulemaking, information on appropriate ways that each qualified clinical decision support mechanism may report the information maintained under subparagraph (B) to the Secretary to support the Secretary in implementing paragraphs (5) and (6).'';

(3) in paragraph (5)—

(A) in the heading, by striking ''OUTLIER'' and inserting ''LOW COMPLIANT'';

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

''(A) IN GENERAL.—With respect to applicable imaging services furnished on or after

January 1, 2027, the Secretary shall determine on an annual basis the total number of ordering professionals who are designated as low compliant ordering professionals under subparagraph (B).

''(B) LOW COMPLIANT ORDERING PROFESSIONALS.—The Secretary shall designate ordering professionals with a compliance rate (as determined under subparagraph (D)) lower than an amount determined by the Secretary as low compliant ordering professionals.'';

(C) in paragraph (C), by striking ''outlier'' and inserting ''low compliant'';

(D) by striking subparagraph (D) and inserting the following:

''(D) DETERMINATION OF COMPLIANCE RATE.—

''(i) IN GENERAL.—

''(I) COMPLIANCE RATES.—For applicable imaging services furnished on or after January 1, 2027, the Secretary shall determine a compliance rate (as defined in clause (ii)) for each ordering professional for a period specified by the Secretary.

"(II) USE OF DATA.—In determining a compliance rate for an ordering professional under subclause (I), the Secretary shall use data made available to the Secretary by qualified clinical decision support mechanisms published in the list under paragraph (3)(C) that were consulted by the ordering professional for the period specified by the Secretary under subclause (I).

"(ii) DEFINITION OF COMPLIANCE RATE.—

"(I) IN GENERAL.—In this subparagraph, the term 'compliance rate' means, with respect to the requirement under paragraph (4)(A)that an order from an ordering professional for an applicable imaging service was the subject of consultation with a qualified decision support mechanism, the ratio (expressed as a percentage) of

"(aa) the number of orders from such ordering professional

included in a report from one or more qualified decision support mechanisms described in paragraph (3)(B); and

''(bb) the aggregate number of such orders from such ordering professional for such period.

''(II) EXCLUSION OF EXCEPTED ORDERS.—In calculating the compliance rate for an ordering professional under subclause (I), the Secretary shall exclude from the total number of orders in item (bb) of such subclause any order for an applicable imaging service described in paragraph (4)(C).''; and

(E) in subparagraph (E), by striking ''outlier'' and inserting ''low compliant'';

(4) by striking paragraph (6) and inserting the following:

''(6) STUDY AND REPORT ON LOW COMPLIANT ORDERING PROFESSIONALS AND UTILIZATION OF APPLICABLE IMAGING SERVICES.—

''(A) IN GENERAL.—Not later than January 1, 2031, and every 5 years thereafter, the

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

''(i) discusses—

''(I) such rates and compliance with this subsection;

''(II) the impact this subsection has on the utilization of applicable imaging services; and

''(III) potential mechanisms for improving compliance with this subsection, including—

''(aa) prior authorization for applicable imaging services ordered by low compliant ordering professionals;

''(bb) any payment adjustment related to the services, or a subset of services, that the Secretary may designate under the fee schedule under section 1848; or

''(cc) other mechanisms determined appropriate by the Secretary; and

"(ii) proposes alternative compliance rate thresholds for low compliant ordering professionals for purposes of paragraph (5)(B).''; and

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

"(8) SPECIALTY SOCIETY ENDORSEMENT.—In specifying applicable appropriate use criteria for applicable imaging services under paragraph (2) and qualified clinical decision support mechanisms under paragraph (3), the Secretary shall substantially adhere to the approach described in section 414.94 of title 42, Code of Federal Regulations (as in effect on January 1, 2023).''.

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

SEC. 208. RULES OF CONSTRUCTION.

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

(1) transfer ownership of a measure developed by a qualified clinical data registry to the Secretary or any other entity without the authorization of the 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.

TITLE III—APM IMPROVEMENT

SEC. 301. QUALIFYING APM PARTICIPANT THRESHOLD FREEZE.

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

(1) in subparagraph (B)—

(A) in the header, by striking ''2026 AND 2028'' and inserting ''2029''; and

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

(2) in subparagraph (C)—

(A) in the header, by striking ''2027 AND 2029'' and inserting ''2030''; and

(B) in the matter preceding clause (i), by striking ''2027 and 2029'' and inserting ''2030''.

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

(1) in subclause (II), in the matter preceding item (aa), by striking ''2026 and 2028'' and inserting ''2029''; and

(2) in subclause (III), the matter preceding item (aa), by striking ''2027 and 2029'' and inserting ''2030''.

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

(1) in subclause (II)—

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

(B) in item (bb), by inserting ''(or such lower percentages as may be specified by the Secretary)'' after ''respectively''; and

(2) in subclause (III)—

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

(B) in item (bb), by inserting ''(or such lower percentages as may be specified by the Secretary)'' after ''respectively''.

SEC. 302. CMI MODEL REQUIREMENTS.

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

(1) in subsection (b)(3)(B), by inserting '', pursuant to notice-and-comment rulemaking,'' after ''The Secretary shall'';

(2) in subsection (c), in the flush matter at the end, by adding at the end the following new sentence: ''The Secretary may terminate a model expanded under this subsection prior to the date set for such termination at the time of such expansion only pursuant to notice and comment rulemaking.''; and

(3) in subsection (g), by adding at the end the following new sentence: ''Each such report submitted in 2027 or a subsequent year shall contain, with respect to each model tested under subsection (b), a description of any savings generated by such model.''.

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

Not later than December 31, 2029, the Comptroller General of the United States, in consultation with the Medicare Payment Advisory Commission, shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, a report on ongoing barriers to participation in value-based payment models for specialty providers under the Medicare program. Such report shall contain specific policy recommendations to reduce such barriers.

TITLE IV—PHYSICIAN PAYMENT IMPROVEMENTS

SEC. 401. UPDATING THE BUDGET NEUTRALITY THRESHOLD.

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

(1) by striking ''Subject to'' and inserting the following:

''(aa) IN GENERAL.—Subject to'';

(2) in item (aa), as inserted by paragraph (1), by striking ''$20,000,000'' and inserting ''the amount specified in item (bb) for such year''; and

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

"(bb) AMOUNT SPECIFIED.—For purposes of item (aa), subject to item (cc), the amount specified in this item is—

"(AA) for years before 2028, $20,000,000;

"(BB) for 2028, $57,640,000; and

"(CC) for 2029 and each subsequent year, the amount specified in this item for the preceding year.

"(cc) INDEXING LIMITATION ON ANNUAL ADJUSTMENTS.—For 2033 and every subsequent fifth year, the Secretary shall increase the amount specified in item (bb) for such year by the cumulative percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to physicians' services for each year occurring during

the 5-year period ending on the last day of the preceding year.''.

SEC. 402. BUDGET NEUTRALITY CORRECTIONS RELATING TO ESTIMATED UTILIZATION.

(a) IN GENERAL.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by adding at the end the following new clause:

''(vii) BUDGET NEUTRALITY CORRECTIONS RELATING TO ESTIMATED UTILIZATION.—

''(I) IN GENERAL.—In the case of a budget neutrality adjustment applied pursuant to clause (ii)(II) for a year (beginning with 2029) that is determined in part using estimated utilization (as defined in subclause (II)(bb)) with respect to a specified service (as defined in subclause (II)(cc)), the Secretary shall, as part of the final rule establishing the physician fee schedule under this section for the assumption correction period (as defined in subclause (II)(aa)) with respect to such year—

''(aa) determine the difference between expenditures for such service in such year using estimated utilization and actual utilization for such service (in a manner determined appropriate by the Secretary); and

''(bb) in the case that the Secretary determines the difference described in item (aa) is greater than the threshold amount (as defined in subclause (II)(dd)) for such year, adjust the conversion factor under this section for such assumption correction period by such amount to reconcile such difference (which may be positive or negative), as determined by the Secretary.

''(II) DEFINITIONS.—For purposes of this clause:

''(aa) ASSUMPTION CORRECTION PERIOD.—The term 'assumption correction period' means, with respect to a year,

the second year beginning after such year.

''(bb) ESTIMATED UTILIZATION.—The term 'estimated utilization' means an estimate of utilization used for purposes of applying clause (ii)(II).

''(cc) SPECIFIED SERVICE.—The term 'specified service' means, with respect to a year, a service—

''(AA) with expected expenditures for such year under this section based on estimated utilization that exceed the threshold amount (as defined in item (dd)) for such year; and

''(BB) for which payment had been bundled into payment for another service during the preceding year and for which a separate payment or add-on payment is made during such year.

"(dd) THRESHOLD AMOUNT.—The term 'threshold amount' means, with respect to a year, 0.1 percent of the total estimated expenditures under this part for services furnished under this section during such year.".

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

(1) in clause (iv)—

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

(B) in subclause (VI), by striking the period and inserting "; and"; and

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

"(VII) clause (vii)(I)(bb) for an assumption correction period (as defined in clause (vii)(II)) shall not be taken into account in applying clause (ii)(II) with respect to such period."; and

(2) in clause (v), by adding at the end the following new subclause:

''(XII) REDUCTIONS ATTRIBUTABLE TO AN ASSUMPTION CORRECTION.—For an assumption correction period (as defined in clause (vii)(II)), reduced expenditures attributable to application of clause (vii)(I)(bb) with respect to such period.''.

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

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

''(viii) TIMELY UPDATES TO DIRECT COSTS USED TO CALCULATE PRACTICE EXPENSE RELATIVE VALUE UNITS.—

''(I) SIMULTANEOUS UPDATES TO DIRECT COST INPUTS AT LEAST ONCE EVERY 5 YEARS.—The Secretary shall, not less often than every 5 years, update the prices and rates, as applicable, on a category-wide basis for each of the categories of direct cost inputs

described in subclause (II) used in the methodology for calculating the practice expense relative value units under this subsection for physicians' services. Updates made pursuant to the previous sentence shall be made in the same year for all categories of direct cost inputs described in such subclause.

''(II) DIRECT COST INPUTS CATEGORIES DESCRIBED.—For purposes of this clause, the categories of direct cost inputs described in this subclause are clinical staff wage rates, prices of medical supplies, prices of equipment, and any other category of such inputs used in the methodology described in subclause (I) (as specified by the Secretary).

''(III) CONSULTATION.—In making the updates under this clause, the Secretary shall consult with relevant stakeholders, including physician specialty societies.''.

SEC. 404. LIMITATION ON YEAR-TO-YEAR CONVERSION FACTOR VARIANCE.

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

''(ix) LIMITATION ON CONVERSION FACTOR VARIANCE.—

''(I) IN GENERAL.—Beginning with 2027, the Secretary may not, for purposes of complying with clause (ii)(II), apply a budget neutrality adjustment to a conversion factor established under subsection (d) for such year that would cause such factor, not taking into account any adjustment to such factor for such year provided under such subsection, to vary by more than 2.5 percent compared to such factor so established for the preceding year.

''(II) CONTINUED APPLICABILITY OF BUDGET NEUTRALITY REQUIREMENT.—Nothing in subclause (I) may be construed to alter the requirement described in clause (ii)(II).''.