

**TITLE 42 - THE PUBLIC HEALTH AND WELFARE**  
**CHAPTER 7 - SOCIAL SECURITY**  
**SUBCHAPTER XVIII - HEALTH INSURANCE FOR AGED AND DISABLED**  
**Part E - Miscellaneous Provisions**

**§ 1395cc–3. Health care quality demonstration program**

**(a) Definitions**

In this section:

**(1) Beneficiary**

The term “beneficiary” means an individual who is entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, including any individual who is enrolled in a Medicare Advantage plan under part C of this subchapter.

**(2) Health care group**

**(A) In general**

The term “health care group” means—

- (i)** a group of physicians that is organized at least in part for the purpose of providing physician’s services under this subchapter;
- (ii)** an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or
- (iii)** an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

**(B) Inclusion**

As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this subchapter that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

**(3) Physician**

Except as otherwise provided for by the Secretary, the term “physician” means any individual who furnishes services that may be paid for as physicians’ services under this subchapter.

**(b) Demonstration projects**

The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

- (1)** the provision of incentives to improve the safety of care provided to beneficiaries;
- (2)** the appropriate use of best practice guidelines by providers and services by beneficiaries;
- (3)** reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;
- (4)** encourage shared decision making between providers and patients;
- (5)** the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;
- (6)** the appropriate use of culturally and ethnically sensitive health care delivery; and
- (7)** the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

**(c) Administration by contract****(1) In general**

Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1395cc–1 of this title is administered in accordance with section 1395cc–2 of this title.

**(2) Alternative payment systems**

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b) of this section; and

(B) streamline documentation and reporting requirements otherwise required under this subchapter.

**(3) Benefits**

A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B of this subchapter or the package of benefits available through a Medicare Advantage plan under part C of this subchapter. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

**(d) Eligibility criteria**

To be eligible to receive assistance under this section, an entity shall—

(1) be a health care group;

(2) meet quality standards established by the Secretary, including—

(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

(C) encouraging patient participation in preference-based decisions;

(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

(3) meet such other requirements as the Secretary may establish.

**(e) Waiver authority**

The Secretary may waive such requirements of this subchapter and subchapter XI of this chapter as may be necessary to carry out the purposes of the demonstration program established under this section.

**(f) Budget neutrality**

With respect to the 5-year period of the demonstration program under subsection (b) of this section, the aggregate expenditures under this subchapter for such period shall not exceed the aggregate

*NB: This unofficial compilation of the U.S. Code is current as of Jan. 5, 2009 (see <http://www.law.cornell.edu/uscode/uscprint.html>).*

expenditures that would have been expended under this subchapter if the program established under this section had not been implemented.

**(g) Notice requirements**

In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this subchapter as a result of the participation of the individual in such program.

**(h) Participation and support by Federal agencies**

In carrying out the demonstration program under this section, the Secretary may direct—

- (1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;
- (2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and
- (3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

(Aug. 14, 1935, ch. 531, title XVIII, § 1866C, as added Pub. L. 108–173, title VI, § 646, Dec. 8, 2003, 117 Stat. 2324.)

**References in Text**

Parts A, B, and C of this subchapter, referred to in subsecs. (a)(1) and (c)(3), are classified to sections 1395c et seq., 1395j et seq., and 1395w–21 et seq., respectively, of this title.

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (h)(3), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see section 1(a) of Pub. L. 104–191, set out as a Short Title of 1996 Amendments note under section 201 of this title and Tables.