Citizens' Council on Health Care

ObamaCare Denies Regulatory Relief

Patient Protection and Affordable Care Act – HR 3590

13 Exemptions From Judicial & Administrative Review

Section	Section Title	Actual Language in ObamaCare	Page
3001	HOSPITAL VALUE-BASED PURCHASING PROGRAM	‘‘(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM… ‘‘(11) IMPLEMENTATION.— ‘‘(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner. ‘‘(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), **there shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of the following: ‘‘(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount. ‘‘(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i). ‘‘(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4). ‘‘(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2). ‘‘(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores. ‘‘(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).	241
3003	IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM	(a) IN GENERAL.—Section 1848(n) of the (42 U.S.C. 1395w–4(n)) is amended… (4)…‘‘(9) REPORTS ON UTILIZATION… ‘‘(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to— ‘‘(i) attribute episodes of care, in whole or in part, to physicians; ‘‘(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and	249

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		‘‘(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measureper individual… ‘‘(G) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determinationof an episode of care under such methodology.	
3007	VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.	(2)‘‘(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER… ‘‘(2) QUALITY.— ‘‘(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)). ‘‘(B) MEASURES.— ‘‘(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary. ‘‘(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a). ‘‘(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary… ‘‘(4) IMPLEMENTATION… ‘‘(B) DEADLINES FOR IMPLEMENTATION…‘‘(ii) INITIAL PERFORMANCE PERIOD.— ‘‘(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015. ‘‘(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period…	258

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		‘‘(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term ‘physician’ has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate. ‘‘(8) DEFINITIONS.—For purposes of this subsection: ‘‘(A) COSTS.—The term ‘costs’ means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians. ‘‘(B) PERFORMANCE PERIOD.—The term ‘performance period’ means a period specified by the Secretary… ‘‘(10) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of— ‘‘(A) the establishment of the value-based payment modifier under this subsection; ‘‘(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B); ‘‘(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph; ‘‘(D) the dates for implementation of the value-based payment modifier; ‘‘(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively; ‘‘(F) the application of the value-based payment modifier under paragraph (7); and ‘‘(G) the determination of costs under paragraph (8)(A).’’.	
3008	PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.	(a) IN GENERAL…(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS…‘‘(2) APPLICABLE HOSPITALS.— ‘‘(A) IN GENERAL.—For purposes of this subsection, the term ‘applicable hospital’ means a subsection (d) hospital that meets the criteria described in subparagraph (B). ‘‘(B) CRITERIA DESCRIBED.— ‘‘(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary. ‘‘(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an	259

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		appropriate risk adjustment methodology. ‘‘(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term ‘hospital acquired condition’ means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary. ‘‘(4) APPLICABLE PERIOD.—In this subsection, the term ‘applicable period’ means, with respect to a fiscal year, a period specified by the Secretary. ‘‘(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period. ‘‘(6) REPORTING HOSPITAL SPECIFIC INFORMATION.— ‘‘(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital. ‘‘(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.— The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public. ‘‘(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format. ‘‘(7) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of the following: ‘‘(A) The criteria described in paragraph (2)(A). ‘‘(B) The specification of hospital acquired conditions under paragraph (3). ‘‘(C) The specification of the applicable period under paragraph (4). ‘‘(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).’’.	
3021	ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.	‘‘(b) TESTING OF MODELS (PHASE I)… ‘‘(3) BUDGET NEUTRALITY.— ‘‘(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title. ‘‘(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and	275

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		implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to— ‘‘(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title; ‘‘(ii) reduce spending under the applicable title without reducing the quality of care; or ‘‘(iii) improve the quality of care and reduce spending. Such termination may occur at any time after such testing has begun and before completion of the testing… ‘‘(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if— ‘‘(1) the Secretary determines that such expansion is expected to— ‘‘(A) reduce spending under applicable title without reducing the quality of care; or ‘‘(B) improve the quality of care and reduce spending; and ‘‘(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles. ‘‘(d) IMPLEMENTATION…‘‘(2) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of— ‘‘(A) the selection of models for testing or expansion under this section; ‘‘(B) the selection of organizations, sites, or participants to test those models selected; ‘‘(C) the elements, parameters, scope, and duration of such models for testing or dissemination; ‘‘(D) determinations regarding budget neutrality under subsection (b)(3); ‘‘(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and ‘‘(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.	
3022	MEDICARE SHARED SAVINGS PROGRAM. [Accountable Care Organizations]	‘‘SEC. 1899. (a) ESTABLISHMENT.—‘‘(1) IN GENERAL… ‘‘(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2). ‘‘(b) ELIGIBLE ACOS… ‘‘(3) QUALITY AND OTHER REPORTING REQUIREMENTS.— ‘‘(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care	280

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		furnished by the ACO, such as measures of— ‘‘(i) clinical processes and outcomes; ‘‘(ii) patient and, where practicable, caregiver experience of care; and ‘‘(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions). ‘‘(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate. ‘‘(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care. ‘‘(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d)… ‘‘(d) PAYMENTS AND TREATMENT OF SAVINGS.— ‘‘(1) PAYMENTS.— ‘‘(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if— ‘‘(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and ‘‘(ii) the ACO meets the requirement under subparagraph (B)(i). ‘‘(B) SAVINGS REQUIREMENT AND BENCHMARK.— ‘‘(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based	

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		upon the number of Medicare fee-for-service beneficiaries assigned to an ACO. ‘‘(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period. ‘‘(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph. ‘‘(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program. ‘‘(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3). ‘‘(g) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of— ‘‘(1) the specification of criteria under subsection (a)(1)(B); ‘‘(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3); ‘‘(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c); ‘‘(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B); ‘‘(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and ‘‘(6) the termination of an ACO under subsection (d)(4).	

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3025	HOSPITAL READMISSIONS REDUCTION PROGRAM.	(a) IN GENERAL…‘‘(q) HOSPITAL READMISSIONS REDUCTION PROGRAM…‘‘ (3) ADJUSTMENT FACTOR.— ‘‘(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of— ‘‘(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or ‘‘(ii) the floor adjustment factor specified in subparagraph (C). ‘‘(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of— ‘‘(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and ‘‘(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period. ‘‘(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for— ‘‘(i) fiscal year 2013 is 0.99; ‘‘(ii) fiscal year 2014 is 0.98; or ‘‘(iii) fiscal year 2015 and subsequent fiscal years is 0.97. ‘‘(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection: ‘‘(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—The term ‘aggregate payments for excess readmissions’ means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of— ‘‘(i) the base operating DRG payment amount for such hospital for such applicable period for such condition; ‘‘(ii) the number of admissions for such condition for such hospital for such applicable period; and ‘‘(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1. ‘‘(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The term ‘aggregate payments for all discharges’ means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period. ‘‘(C) EXCESS READMISSION RATIO.— ‘‘(i) IN GENERAL.—Subject to clause (ii), the term ‘excess readmissions ratio’ means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of— ‘‘(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an	293

		applicable hospital for such condition with respect to such applicable period; to ‘‘(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period. ‘‘(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital. ‘‘(5) DEFINITIONS.—For purposes of this subsection: ‘‘(A) APPLICABLE CONDITION.—The term ‘applicable condition’ means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which— ‘‘(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and ‘‘(ii) measures of such readmissions— ‘‘(I) have been endorsed by the entity with a contract under section 1890(a); and ‘‘(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital). ‘‘(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. ‘‘(C) APPLICABLE HOSPITAL.—The term ‘applicable hospital’ means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be. ‘‘(D) APPLICABLE PERIOD.—The term ‘applicable period’ means, with respect to a fiscal year, such period as the Secretary shall specify. ‘‘(E) READMISSION.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such	

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		discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure… ‘‘(7) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of the following: ‘‘(A) The determination of base operating DRG payment amounts. ‘‘(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5). ‘‘(C) The measures of readmissions as described in paragraph (5)(A)(ii).	
3133	IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.	(2) ‘‘(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS… ‘‘(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors: ‘‘(A) FACTOR ONE.—A factor equal to the difference between— ‘‘(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and ‘‘(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated). ‘‘(B) FACTOR TWO.— ‘‘(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals— ‘‘(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and ‘‘(II) who are uninsured in the most recent period for which data is available (as so calculated). ‘‘(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals— ‘‘(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and	315

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		‘‘(II) who are uninsured in the most recent period for which data is available (as so estimated and certified). ‘‘(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of— ‘‘(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and ‘‘(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data). ‘‘(3) LIMITATIONS ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878 or otherwise of the following: ‘‘(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2). ‘‘(B) Any period selected by the Secretary for such purposes.’’.	
3403	INDEPENDENT MEDICARE ADVISORY BOARD.	‘‘(e) IMPLEMENTATION OF PROPOSAL.— ‘‘(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted. ‘‘(5) LIMITATION ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.	382
5501	EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.	(a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES.— (1) IN GENERAL.—‘‘(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.— ‘‘(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part. ‘‘(2) DEFINITIONS.—In this subsection: ‘‘(A) PRIMARY CARE PRACTITIONER.—The term ‘primary care practitioner’ means an individual—	535

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		‘‘(i) who— ‘‘(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or ‘‘(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and ‘‘(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary. ‘‘(B) PRIMARY CARE SERVICES.—The term ‘primary care services’ means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary): ‘‘(i) 99201 through 99215. ‘‘(ii) 99304 through 99340. ‘‘(iii) 99341 through 99350… ‘‘(4) LIMITATION ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.’’.	
6001	LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.	(a) IN GENERAL…(3)‘‘(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION…‘‘(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY… ‘‘(H) LIMITATION ON REVIEW.—**There shall be no administrative or judicial review** under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).	570
6401	PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.	(a) MEDICARE…‘‘(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.— ‘‘(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program. ‘‘(B) LIMITATION ON REVIEW.—**There shall be no judicial review** under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).	633

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10409	CURES ACCELERATION NETWORK.	(d) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK… ‘‘SEC. 402C. CURES ACCELERATION NETWORK. ‘‘(a) DEFINITIONS… ‘‘(3) HIGH NEED CURE.—The term ‘high need cure’ means a drug (as that term is defined by section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act, biological product (as that term is defined by section 262(i)), or device (as that term is defined by section 201(h) of the Federal Food, Drug, and Cosmetic Act) that, in the determination of the Director of NIH— ‘‘(A) is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition; and ‘‘(B) for which the incentives of the commercial market are unlikely to result in its adequate or timely development. ‘‘(e) GRANT PROGRAM…‘‘(7) REVIEW.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need cure (for purposes of subsection (a)(3)) **shall not be subject to judicial review**.	866