Union Calendar No. 283

113TH CONGRESS
2D SESSION

H. R. 2810

[Report No. 113–257, Parts I and II]

To amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians' services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2013

Mr. BURGESS (for himself, Mr. PALLONE, Mr. UPTON, Mr. WAXMAN, Mr. PITTS, and Mr. DINGELL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

NOVEMBER 12, 2013

Reported from the Committee on Energy and Commerce with an amendment

[Strike out all after the enacting clause and insert the part printed in italic]

NOVEMBER 12, 2013

The Committee on the Judiciary discharged

NOVEMBER 12, 2013

Referral to the Committee on Ways and Means extended for a period ending not later than December 2, 2013

DECEMBER 2, 2013

Referral to the Committee on Ways and Means extended for a period ending not later than January 10, 2014

JANUARY 10, 2014

Referral to the Committee on Ways and Means extended for a period ending not later than March 14, 2014

MARCH 14, 2014

Additional sponsors: Mr. CASSIDY, Mr. BUCSHON, Mrs. CHRISTENSEN, Mr. GINGREY of Georgia, Mr. STOCKMAN, Mr. THORNBERRY, Mr. BENISHEK, Mr. MURPHY of Pennsylvania, Mr. GOSAR, Ms. MATSUI, Ms. CASTOR of Florida, Mr. ENGEL, Mr. CUELLAR, Mr. SESSIONS, Mr. YOUNG of Alaska, Mr. GENE GREEN of Texas, Mr. OLSON, Mrs. ELLMERS, Mr. ROE of Tennessee, Mrs. BLACKBURN, Mr. LATTA, Mrs. MCMORRIS RODGERS, Mr. TERRY, Mr. ROGERS of Michigan, Mr. WALDEN, Mr. BILIRAKIS, Ms. SCHAKOWSKY, Mr. BRALEY of Iowa, Mrs. CAPPS, Mr. CARTER, Mr. BARTON, Mr. WHITFIELD, Mr. LANCE, Mr. HOLDING, Mr. WESTMORELAND, Mr. LATHAM, Mrs. BROOKS of Indiana, Mr. WALBERG, Mr. RICE of South Carolina, Mr. LOEBSACK, Mr. COFFMAN, Mr. BERA of California, Mr. RUIZ, Mr. STIVERS, Mr. MCKINLEY, Mr. KENNEDY, Mr. BEN RAY LUJÁN of New Mexico, Mr. RUSH, Mr. YODER, Mr. MARINO, Mr. MCNERNEY, and Mr. LANGEVIN

MARCH 14, 2014

Reported from the Committee on Ways and Means with an amendment, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Strike out all after the enacting clause and insert the part printed in boldface roman]

[For text of introduced bill, see copy of bill as introduced on July 24, 2013]

A BILL

To amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians' services, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Patient Access and Quality Improvement Act of 2013".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. REFORM OF SUSTAINABLE GROWTH RATE (SGR) AND MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(a) STABILIZING FEE UPDATES (PHASE I).—

(1) REPEAL OF SGR PAYMENT METHODOLOGY.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting "or a subsequent paragraph or section 1848A" after "paragraph (4)"; and

(ii) in paragraph (4)—

(I) in the heading, by striking "YEARS BEGINNING WITH 2001" and inserting "2001, 2002, AND 2003"; and

(II) in subparagraph (A), by striking "a year beginning with 2001" and inserting "2001, 2002, and 2003"; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting "through 2013" after "of each succeeding year"; and

(ii) in paragraph (2), by inserting "and ending with 2013" after "beginning with 2000".

(2) UPDATE OF RATES FOR 2014 THROUGH 2018.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

"(15) UPDATE FOR 2014 THROUGH 2018.—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 through 2018 shall be 0.5 percent.".

(b) QUALITY UPDATE INCENTIVE PROGRAM (PHASE II).—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (a), is further amended—

(A) in subsection (d), by adding at the end the following new paragraph:

"(16) UPDATE BEGINNING WITH 2019.—

"(A) IN GENERAL.—Subject to subparagraph (B), the update to the single conversion factor established in paragraph (1)(C) for each year beginning with 2019 shall be 0.5 percent.

"(B) ADJUSTMENT.—In the case of an eligible professional (as defined in subsection (k)(3)) who does not have a payment arrangement described in section 1848A(a) in effect, the update under subparagraph (A) for a year beginning with 2019 shall be adjusted by the applicable quality adjustment determined under subsection (q)(3) for the year involved."; and

(B) in subsection (i)(1)—

(i) by striking "and" at the end of subparagraph (D);

(ii) by striking the period at the end of subparagraph (E) and inserting ", and"; and

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

"(F) the implementation of subsection (q).".

(2) ENHANCING PHYSICIAN QUALITY REPORTING SYSTEM TO SUPPORT QUALITY UPDATE INCENTIVE PROGRAM.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (k)(1), in the first sentence, by inserting "and, if applicable, clinical practice improvement activities," after "quality measures";

(B) in subsection (k)(2)—

(i) in subparagraph (C)—

(I) in the subparagraph heading, by striking "AND SUBSEQUENT YEARS" and inserting "THROUGH 2018"; and

(II) in clause (i), by inserting "(before 2019)" after "subsequent year";

(ii) by redesignating subparagraph (D) as subparagraph (E);

(iii) by inserting after subparagraph (C) the following new subparagraph:

"(D) FOR 2019 AND SUBSEQUENT YEARS.—For purposes of reporting data on quality meas-

ures and, as applicable clinical practice improvement activities, for covered professional services furnished during the performance period (as defined in subsection (q)(2)(B)) with respect to 2019 and the performance period with respect to each subsequent year, subject to subsection (q)(1)(D), the quality measures and clinical practice improvement activities specified under this paragraph shall be, with respect to an eligible professional, the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under paragraph (9)(F) applicable to the peer cohort of such provider and year involved.''; and

(iv) in subparagraph (E), as redesignated by subparagraph (B)(ii) of this paragraph, by striking ''AND SUBSEQUENT YEARS'';

(C) in subsection (k)(3)—

(i) in the paragraph heading, by striking ''COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED'' and inserting ''DEFINITIONS''; and

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

"(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—The term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

"(D) ELIGIBLE PROFESSIONAL ORGANIZATION.—The term 'eligible professional organization' means a professional organization as defined by nationally recognized multispecialty boards of certification or equivalent certification boards.

"(E) PEER COHORT.—The term 'peer cohort' means a peer cohort identified on the list under paragraph (9)(B), as updated under clause (ii) of such paragraph.";

(D) in subsection (k)(7), by striking " and the application of paragraphs (4) and (5)" and inserting ", the application of paragraphs (4) and (5), and the implementation of paragraph (9)";

(E) by adding at the end of subsection (k) the following new paragraph:

"(9) ESTABLISHMENT OF FINAL CORE MEASURE SETS.—

"(A) IN GENERAL.—Under the system under this subsection—

"(i) for each peer cohort identified under subparagraph (B) and in accordance with this paragraph, there shall be published a final core measure set under subparagraph (F), which shall consist of quality measures and may also consist of clinical practice improvement activities, with respect to which eligible professionals shall, subject to subsection (m)(3)(C), be assessed for purposes of determining, for years beginning with 2019, the quality adjustment under subsection (q)(3) applicable to such professionals; and

"(ii) each eligible professional shall self-identify, in accordance with subparagraph (B), within such a peer cohort for purposes of such assessments.

"(B) PEER COHORTS.—The Secretary shall identify (and publish a list of) peer cohorts by which eligible professionals shall self-identify for purposes of this subsection and subsection (q)

with respect to a performance period (as defined in subsection (q)(2)(B)) for a year beginning with 2019. For purposes of this subsection and subsection (q), the Secretary shall develop one or more peer cohorts for multispecialty groups, each of which shall be included as a peer cohort under this subparagraph. Such self-identification will be made through such a process and at such time as specified under the system under this subsection. Such list—

"(i) shall include, as peer cohorts, provider specialties defined by nationally recognized multispecialty boards of certification or equivalent certification boards and such other cohorts as established under this section in order to capture classifications of providers across eligible professional organizations and other practice areas, groupings, or categories; and

"(ii) shall be updated from time to time.

"(C) QUALITY MEASURES FOR CORE MEASURE SETS.—

"(i) DEVELOPMENT.—Under the system under this subsection there shall be es-

tablished a process for the development of quality measures under this subparagraph for purposes of potential inclusion of such measures in core measure sets under this paragraph. Under such process—

"(I) there shall be coordination, to the extent possible, across organizations developing such measures;

"(II) eligible professional organizations and other relevant stakeholders may submit best practices and clinical practice guidelines for the development of quality measures that address quality domains (as defined under clause (ii)) for potential inclusion in such core measure sets;

"(III) there is encouraged to be developed, as appropriate, meaningful outcome measures (or quality of life measures in cases for which outcomes may not be a valid measurement), functional status measures, and patient experience measures; and

"(IV) measures developed under this clause shall be developed, to the ex-

tent possible, in accordance with best practices and clinical practice guidelines.

"(ii) QUALITY DOMAINS.—For purposes of this paragraph, the term 'quality domains' means at least the following domains:

"(I) Clinical care.

"(II) Safety.

"(III) Care coordination.

"(IV) Patient and caregiver experience.

"(V) Population health and prevention.

"(D) PROCESS FOR ESTABLISHING CORE MEASURE SETS.—

"(i) IN GENERAL.—Under the system under this subsection, for purposes of subparagraph (A), there shall be established a process to approve final core measure sets under this paragraph for peer cohorts. Each such final core measure set shall be composed of quality measures (and, as applicable, clinical practice improvement activities) with respect to which eligible profes-

sionals within such peer cohort shall report under this subsection and be assessed under subsection (q). Such process shall provide—

"(I) for the establishment of criteria, which shall be made publicly available before the request is made under clause (ii), for selecting such measures and activities for potential inclusion in such a final core measure set; and

"(II) that all peer cohorts, and to the extent practicable all quality domains, are addressed by measures and, as applicable, clinical practice improvement activities selected to be included in a core measure set under this paragraph, which may include through the use of such a measure or clinical practice improvement activity that addresses more than one such domain or cohort.

"(ii) SOLICITATION OF PUBLIC INPUT ON QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Under the process established under clause (i), relevant

eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures and clinical practice improvement activities (as defined in paragraph (3)(C)) for selection under this paragraph. For purposes of the previous sentence, measures and activities may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

"(E) CORE MEASURE SETS.—

"(i) IN GENERAL.—Under the process established under subparagraph (D)(i), the Secretary—

"(I) shall select, from quality measures described in clause (ii) applicable to a peer cohort, quality measures to be included in a core measure set for such cohort;

"(II) shall, to the extent there are insufficient quality measures applicable to a peer cohort to address one or more applicable quality domains, select to be included in a core measure set for

such cohort such clinical practice improvement activities described in clause (ii)(IV) as are needed and available to sufficiently address such an applicable domain with respect to such peer cohort; and

"(III) may select, to the extent determined appropriate, any additional clinical practice improvement activities described in clause (ii)(IV) applicable to a peer cohort to be included in a core measure set for such cohort.

Activities selected under this paragraph shall be selected with consideration of best practices and clinical practice guidelines identified under subparagraph (C)(i)(II).

"(ii) SOURCES OF QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—A quality measure or clinical practice improvement activity selected for inclusion in a core measure set under the process under subparagraph (D)(i) shall be—

"(I) a measure endorsed by a consensus-based entity;

"(II) a measure developed under paragraph (2)(C) or a measure otherwise applied or developed for a similar purpose under this section;

"(III) a measure developed under subparagraph (C); or

"(IV) a measure or activity submitted under subparagraph (D)(ii).

A measure or activity may be selected under this subparagraph, regardless of whether such measure or activity was previously published in a proposed rule. A measure so selected shall be evidence-based but (other than a measure described in subclause (I)) shall not be required to be consensus-based.

"(iii) TRANSPARENCY.—Before publishing in a final regulation a core measure set under clause (i) as a final core measure set under subparagraph (F), the Secretary shall—

"(I) submit for publication in applicable specialty-appropriate peer-reviewed journals such core measure set under clause (i) and the method for developing and selecting measures within

such set, including clinical and other data supporting such measures, and, as applicable, the method for selecting clinical practice improvement activities included within such set; and

"(II) regardless of whether or not the core measure set or method is published in such a journal under subclause (I), provide for notice of the proposed regulation in the Federal Register, including with respect to the applicable methods and data described in subclause (I), and a period for public comment thereon.

"(F) FINAL CORE MEASURE SETS.—Not later than November 15 of the year prior to the first day of a performance period, the Secretary shall publish a final regulation in the Federal Register that includes a final core measure set (and the applicable methods and data described in subparagraph (E)(iii)(I)) for each peer cohort to be applied for such performance period.

"(G) PERIODIC REVIEW AND UPDATES.—

"(i) IN GENERAL.—In carrying out this paragraph, under the system under this

subsection, there shall periodically be reviewed—

"(I) the quality measures and clinical practice improvement activities selected for inclusion in final core measure sets under this paragraph for each year such measures and activities are to be applied under this subsection or subsection (q) to ensure that such measures and activities continue to meet the conditions applicable to such measures and activities for such selection; and

"(II) the final core measure sets published under subparagraph (F) for each year such sets are to be applied to peer cohorts of eligible professionals to ensure that each applicable set continues to meet the conditions applicable to such sets before being so published.

"(ii) COLLABORATION WITH STAKEHOLDERS.—In carrying out clause (i), relevant eligible professional organizations and other relevant stakeholders may identify

and submit updates to quality measures and clinical practice improvement activities selected under this paragraph for inclusion in final core measure sets as well as any additional quality measures and clinical practice improvement activities. Not later than November 15 of the year prior to the first day of a performance period, submissions under this clause shall be reviewed.

"(iii) ADDITIONAL, AND UPDATES TO, MEASURES AND ACTIVITIES.—Based on the review conducted under this subparagraph for a period, as needed, there shall be—

"(I) selected additional, and updates to, quality measures and clinical practice improvement activities selected under this paragraph for potential inclusion in final core measure sets in the same manner such quality measures and clinical practice improvement activities are selected under this paragraph for such potential inclusion;

"(II) removed, from final core measure sets, quality measures and

clinical practice improvement activities that are no longer meaningful; and

"(III) updated final core measure sets published under subparagraph (F) in the same manner as such sets are approved under such subparagraph.

For purposes of this subsection and subsection (q), a final core measure set, as updated under this subparagraph, shall be treated in the same manner as a final core measure set published under subparagraph (F).

"(iv) TRANSPARENCY.—

"(I) NOTIFICATION REQUIRED FOR CERTAIN UPDATES.—In the case of an update under subclause (II) or (III) of clause (iii) that adds, materially changes, or removes a measure or activity from a measure set, such update shall not apply under this subsection or subsection (q) unless notification of such update is made available to applicable eligible professionals.

"(II) PUBLIC AVAILABILITY OF UPDATED FINAL CORE MEASURE

SETS.—Subparagraph (E)(iii) shall apply with respect to measure sets updated under subclause (II) or (III) of clause (iii) in the same manner as such subparagraph applies to applicable core measure sets under subparagraph (E).

"(H) COORDINATION WITH EXISTING PROGRAMS.—The development and selection of quality measures and clinical practice improvement activities under this paragraph shall, as appropriate, be coordinated with the development and selection of existing measures and requirements, such as the development of the Physician Compare Website under subsection (m)(5)(G) and the application of resource use management under subsection (n). To the extent feasible, such measures and activities shall align with measures used by other payers and with measures and activities in use under other programs in order to streamline the process of such development and selection under this paragraph. The Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relat-

ing to the meaningful use of certified EHR technology.

"(I) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations (as defined in paragraph (3)(D)) and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this paragraph.

"(J) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the development or selection of measures under this paragraph."; and

(F) in subsection (m)(3)(C)(i), by adding at the end the following new sentence: "Such process shall, beginning for 2019, treat eligible professionals in such a group practice as reporting on measures for purposes of application of subsections (q) and (a)(8)(A)(iii) if, in lieu of reporting measures under subsection (k)(2)(D), the group practice reports measures determined appropriate by the Secretary.".

(3) ESTABLISHMENT OF QUALITY UPDATE INCENTIVE PROGRAM.—

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

"(q) QUALITY UPDATE INCENTIVE PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish an eligible professional quality update incentive program (in this section referred to as the 'quality update incentive program') under which—

"(i) there is developed and applied, in accordance with paragraph (2), appropriate methodologies for assessing the performance of eligible professionals with respect to quality measures and clinical practice improvement activities included within the final core measure sets published under subsection (k)(9)(F) applicable to the peer cohorts of such providers;

"(ii) there is applied, consistent with the system under subsection (k), methods for collecting information needed for such assessments (which shall involve the minimum

amount of administrative burden required to ensure reliable results); and

"(iii) the applicable update adjustments under paragraph (3) are determined by such assessments.

"(B) DEFINITIONS.—

"(i) ELIGIBLE PROFESSIONAL.—In this subsection, the term 'eligible professional' has the meaning given such term in subsection (k)(3), except that such term shall not include a professional who has a payment arrangement described in section 1848A(a)(1) in effect.

"(ii) PEER COHORTS; CLINICAL PRACTICE IMPROVEMENT ACTIVITIES; ELIGIBLE PROFESSIONAL ORGANIZATIONS.—In this subsection, the terms 'peer cohort', 'clinical practice improvement activity', and 'eligible professional organization' have the meanings given such terms in subsection (k)(3).

"(C) CONSULTATION WITH ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Eligible professional organizations and other relevant stakeholders, in-

cluding State and national medical societies, shall be consulted in carrying out this subsection.

"(D) APPLICATION AT GROUP PRACTICE LEVEL.—The Secretary shall establish a process, consistent with subsection (m)(3)(C), under which the provisions of this subsection are applied to eligible professionals in a group practice if the group practice reports measures determined appropriate by the Secretary under such subsection.

"(E) COORDINATION WITH EXISTING PROGRAMS.—The application of measures and clinical practice improvement activities and assessment of performance under this subsection shall, as appropriate, be coordinated with the application of measures and assessment of performance under other provisions of this section.

"(2) ASSESSING PERFORMANCE WITH RESPECT TO FINAL CORE MEASURE SETS FOR APPLICABLE PEER COHORTS.—

"(A) ESTABLISHMENT OF METHODS FOR ASSESSMENT.—

"(i) IN GENERAL.—Under the quality update incentive program, the Secretary shall—

"(I) establish one or more methods, applicable with respect to a performance period, to assess (using a scoring scale of 0 to 100) the performance of an eligible professional with respect to, subject to paragraph (1)(D), quality measures and clinical practice improvement activities included within the final core measure set published under subsection (k)(9)(F) applicable for the period to the peer cohort in which the provider self-identified under subsection (k)(9)(B) for such period; and

"(II) subject to paragraph (1)(D), compute a composite score for such provider for such performance period with respect to the measures and activities included within such final core measure set.

"(ii) METHODS.—Such methods shall, with respect to an eligible professional, provide that the performance of such professional shall, subject to paragraph (1)(D), be assessed for a performance period with re-

spect to the quality measures and clinical practice improvement activities within the final core measure set for such period for the peer cohort of such professional and on which information is collected from such professional.

"(iii) WEIGHTING OF MEASURES.—Such a method may provide for the assignment of different scoring weights or, as appropriate, other factors—

"(I) for quality measures and clinical practice improvement activities;

"(II) based on the type or category of measure or activity; and

"(III) based on the extent to which a quality measure or clinical practice improvement activity meaningfully assesses quality.

"(iv) RISK ADJUSTMENT.—Such a method shall provide for appropriate risk adjustments.

"(v) INCORPORATION OF OTHER METHODS OF MEASURING PHYSICIAN QUALITY.—In establishing such methods, there shall be,

as appropriate, incorporated comparable methods of measurement from physician quality incentive programs under this subsection.

"(B) PERFORMANCE PERIOD.—There shall be established a period (in this subsection referred to as a 'performance period'), with respect to a year (beginning with 2019) for which the quality adjustment is applied under paragraph (3), to assess performance on quality measures and clinical practice improvement activities. Each such performance period shall be a period of 12 consecutive months and shall end as close as possible to the beginning of the year for which such adjustment is applied.

"(3) QUALITY ADJUSTMENT TAKING INTO ACCOUNT QUALITY ASSESSMENTS.—

"(A) QUALITY ADJUSTMENT.—For purposes of subsection (d)(16), if the composite score computed under paragraph (2)(A) for an eligible professional for a year (beginning with 2019) is—

"(i) a score of 67 or higher, the quality adjustment under this paragraph for the el-

igible professional and year is 1 percentage point;

"(ii) a score of at least 34, but below 67, the quality adjustment under this paragraph for the eligible professional and year is zero; or

"(iii) a score below 34, the quality adjustment under this paragraph for the eligible professional and year is -1 percentage point.

"(B) NO EFFECT ON SUBSEQUENT YEARS' QUALITY ADJUSTMENTS.—Each such quality adjustment shall be made each year without regard to the quality adjustment for a previous year under this paragraph.

"(4) TRANSITION FOR NEW ELIGIBLE PROFESSIONALS.—In the case of a physician, practitioner, or other supplier that during a performance period, with respect to a year for which a quality adjustment is applied under paragraph (3), first becomes an eligible professional (and had not previously submitted claims under this title as a person, as an entity, or as part of a physician group or under a different billing number or tax identifier), the quality adjustment

under this subsection applicable to such physician, practitioner, or supplier—

"(A) for such year, with respect to such first performance period, shall be zero; and

"(B) for a year, with respect to a subsequent performance period, shall be the quality adjustment that would otherwise be applied under this subsection.

"(5) FEEDBACK.—

"(A) FEEDBACK.—

"(i) ONGOING FEEDBACK.—Under the process under subsection (m)(5)(H), there shall be provided, as real time as possible, but at least quarterly, beginning not later than 6 months after the first day of the first performance period, to each eligible professional feedback—

"(I) on the performance of such provider with respect to quality measures and clinical practice improvement activities within the final core measure set published under subsection (k)(9)(F) for the applicable performance period and the peer cohort of such professional; and

"(II) to assess the progress of such professional under the quality update incentive program with respect to a performance period for a year.

"(ii) USE OF REGISTRIES AND OTHER MECHANISMS.—Feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided and based on performance received through the use of such registry, and to the extent that an eligible professional chooses not to participate in such a registry for such purposes, be provided through other similar mechanisms that allow for the provision of such feedback and receipt of such performance information.

"(B) DATA MECHANISM.—Under the quality update incentive program, there shall be developed an electronic interactive eligible professional mechanism through which such a professional may receive performance data, including data with respect to performance on the measures and activities developed and selected under

this section. Such mechanism shall be developed in consultation with private payers and health insurance issuers (as defined in section 2791(b)(2) of the Public Health Service Act) as appropriate.

"(C) TRANSFER OF FUNDS.—The Secretary shall provide for the transfer of $100,000,000 from the Federal Supplementary Medical Insurance Trust Fund established in section 1841 to the Center for Medicare & Medicaid Services Program Management Account to support such efforts to develop the infrastructure as necessary to carry out subsection (k)(9) and this subsection and for purposes of section 1889(h). Such funds shall be so transferred on the date of the enactment of this subsection and shall remain available until expended.".

(B) INCENTIVE TO REPORT UNDER QUALITY UPDATE INCENTIVE PROGRAM.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking "With respect to" and inserting "Subject to clause (iii), with respect to"; and

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

"(iii) APPLICATION TO ELIGIBLE PROFESSIONALS NOT REPORTING.—With respect to covered professional services (as defined in subsection (k)(3)) furnished by an eligible professional during 2019 or any subsequent year, if the eligible professional does not submit data for the performance period (as defined in subsection (q)(2)(B)) with respect to such year on, subject to subsection (q)(1)(D), the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under subsection (k)(9)(F) applicable to the peer cohort of such provider, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to 95 percent (in lieu of the applicable percent) of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5),

and (7), but without regard to this paragraph). The Secretary shall develop a minimum per year caseload threshold, with respect to eligible professionals, and the previous sentence shall not apply to eligible professionals with a caseload for a year below such threshold for such year.''.

(C) EDUCATION ON QUALITY UPDATE INCENTIVE PROGRAM.—Section 1889 of the Social Security Act (42 U.S.C. 1395zz) is amended by adding at the end the following new subsection:

''(h) QUALITY UPDATE INCENTIVE PROGRAM.—Under this section, information shall be disseminated to educate and assist eligible professionals (as defined in section 1848(k)(3)) about the quality update incentive program under section 1848(q) and quality measures under section 1848(k)(9) through multiple approaches, including a national dissemination strategy and outreach by medicare contractors.''.

(4) CONFORMING AMENDMENTS.—

(A) TREATMENT OF SATISFACTORILY REPORTING PQRS MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is

amended by striking "For 2014 and subsequent years" and inserting "For each of 2014 through 2018".

(B) COORDINATING ENHANCED PQRS REPORTING WITH EHR.—Section 1848(o)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(B)(iii)) is amended by striking "subsection (k)(2)(C)" and inserting "subparagraph (C) or (D) of subsection (k)(2)".

(C) COORDINATING PQRS REPORTING PERIOD WITH QUALITY UPDATE INCENTIVE PROGRAM PERFORMANCE PERIOD.—Section 1848(m)(6)(C) of the Social Security Act (42 U.S.C. 1395w–4(m)(6)(C)) is amended—

(i) in clause (i), by striking "and (iii)" and inserting ", (iii), and (iv)"; and

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

"(iv) COORDINATION WITH QUALITY UPDATE INCENTIVE PROGRAM.—For 2019 and each subsequent year the reporting period shall be coordinated with the performance period under subsection (q)(2)(B).".

(D) COORDINATING EHR REPORTING WITH QUALITY UPDATE INCENTIVE PROGRAM PER-

FORMANCE PERIOD.—Section 1848(o)(5)(B) of the Social Security Act (42 U.S.C. 1395w–4(o)(5)(B)) is amended by adding at the end the following: "Beginning for 2019, the EHR reporting period shall be coordinated with the performance period under subsection (q)(2)(B).".

(c) ADVANCING ALTERNATIVE PAYMENT MODELS.—

(1) IN GENERAL.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395w–4 et seq.) is amended by adding at the end the following new section:

"SEC. 1848A. ADVANCING ALTERNATIVE PAYMENT MODELS.

"(a) PAYMENT MODEL CHOICE PROGRAM.—Payment for covered professional services (as defined in section 1848(k)) that are furnished by an eligible professional (as defined in such section) under an Alternative Payment Model specified on the list under subsection (h) (in this section referred to as an 'eligible APM') shall be made under this title in accordance with the payment arrangement under such model. In applying the previous sentence, such a professional with such a payment arrangement in effect, shall be deemed for purposes of section 1848(a)(8) to be satisfactorily submitting data on quality measures for such covered professional services.

"(b) PROCESS FOR IMPLEMENTING ELIGIBLE APMS.—

"(1) IN GENERAL.—For purposes of subsection (a) and in accordance with this section, the Secretary shall establish a process under which—

"(A) a contract is entered into, in accordance with paragraph (2);

"(B) proposals for potential Alternative Payment Models are submitted in accordance with subsection (c);

"(C) Alternative Payment Models so proposed are recommended, in accordance with subsection (d), for testing and evaluation, including through the demonstration program under subsection (e), and approval under subsection (f);

"(D) applicable Alternative Payment Models are tested and evaluated under such demonstration program;

"(E) models are implemented as eligible APMs in accordance with subsection (f); and

"(F) a comprehensive list of all eligible APMs is made publicly available, in accordance with subsection (h), for application under subsection (a).

"(2) CONTRACT WITH APM CONTRACTING ENTITY.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the Secretary shall identify and have in effect a contract with an independent entity that has appropriate expertise to carry out the functions applicable to such entity under this section. Such entity shall be referred to in this section as the 'APM contracting entity'.

"(B) TIMING FOR FIRST CONTRACT.—The Secretary shall enter into the first contract under subparagraph (A) to be in effect January 1, 2019.

"(C) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)) shall be used to enter into a contract under subparagraph (A).

"(c) SUBMISSION OF PROPOSED ALTERNATIVE PAYMENT MODELS.—Beginning not later than 90 days after the date the Secretary enters into a contract under subsection (b)(2) with the APM contracting entity, physicians, eligible professional organizations, health care provider organizations, and other entities may submit to the APM contracting entity proposals for Alternative Payment Models

for application under this section. Such a proposal of a model shall include suggestions for measures to be used under subsection (e)(1)(B) for purposes of evaluating such model. In reviewing submissions under this subsection for purposes of making recommendations under subsection (d)(1), the contracting entity shall focus on submissions for such models that are intended to improve care coordination and quality for patients through modifying the manner in which physicians and other providers are paid under this title.

"(d) RECOMMENDATION BY APM CONTRACTING ENTITY OF PROPOSED MODELS.—

"(1) RECOMMENDATION.—

"(A) RECOMMENDATIONS TO SECRETARY.—

"(i) IN GENERAL.—Under the process under subsection (b), the APM contracting entity shall at least quarterly recommend, in accordance with clause (ii), to the Secretary—

"(I) Alternative Payment Models submitted under subsection (c) to be tested and evaluated through a demonstration program under subsection (e); and

"(II) Alternative Payment Models submitted under subsection (c) to be implemented under subsection (f) without testing and evaluation through such a demonstration program.

Such a recommendation under subclause (I) may be made with respect to a model for which a waiver would be required under paragraph (2). Any reference in this subsection to an Alternative Payment Model under this clause is a reference to such model as may be modified under clause (iii).

"(ii) REQUIREMENTS.—In recommending an Alternative Payment Model under clause (i), each of the following shall apply:

"(I) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(I) only if the entity determines that the model satisfies the criteria described in subparagraph (B), including the criteria described in subparagraph (B)(iv).

"(II) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(II) only if the entity determines that the model satisfies the criteria described in subparagraph (C), including the criteria described in subparagraph (C)(iii).

"(III) The APM contracting entity shall include with the recommended Alternative Payment Model recommendations for rules of coordination described in clause (v).

"(iii) MODIFICATIONS BY APM CONTRACTING ENTITY.—For purposes of this subparagraph, to the extent necessary to meet the applicable requirements of clause (ii), the APM contracting entity may modify an Alternative Payment Model submitted under subsection (c) to ensure that the model would—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of care without increasing spending under this title.

"(iv) FORMS OF MODIFICATIONS.—Such a modification under clause (iii) may include one or more of the following:

"(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

"(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that the requirement described in subclause (I) or (II) is satisfied.

"(III) A change to the rules of coordination described in clause (v).

"(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

"(V) Such other change as the contracting entity may specify.

"(v) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(I) IN GENERAL.—Rules of coordination described in this clause for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

"(II) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

"(III) APPLICATION TO NON-APM PAYMENT.—In applying such rules of coordination for purposes of section 1848(d)(16), an eligible professional

shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

"(B) CRITERIA FOR RECOMMENDING MODELS FOR DEMONSTRATION.—For purposes of subparagraph (A)(ii)(I), the criteria described in this subparagraph, with respect to an Alternative Payment Model, are each of the following:

"(i) The model has been supported by meaningful clinical and non-clinical data, with respect to a sufficient population sample, that indicates the model would be successful at addressing each of the abilities described in clause (iv).

"(ii)(I) In the case of a model that has already been evaluated and supported by data with respect to a population of individuals enrolled under this part, if the model were evaluated under the demonstration under subsection (e) such a population would represent a sufficient number of individuals enrolled under this part to ensure a

meaningful evaluation of the likely effect of expanding the demonstration.

"(II) In the case of a model that has not been so evaluated and supported by data with respect to such a population, the population that would be furnished services under such model if the model were evaluated under the demonstration under subsection (e) would represent a sufficient number of individuals enrolled under this part to ensure a meaningful evaluation of the likely effect of expanding the demonstration.

"(iii) Such model, including if tested and evaluated under the demonstration under subsection (e), would not deny or limit the coverage or provision of benefits under this title for applicable individuals.

"(iv) The proposal for such model demonstrates—

"(I) the significant likelihood to successfully manage the cost of furnishing items and services under this title so as to not result in expenditures under this title being greater than ex-

penditures under this title if the APM were not implemented; and

"(II) the ability to maintain or improve the overall quality of patient care provided to individuals enrolled under this part.

"(v) The model provides for a payment arrangement—

"(I) that specifies the items and services covered under the arrangement and specifies rules of coordination described in subparagraph (A)(v) between the items and services covered under the arrangement and other items and services not covered under the arrangement;

"(II) in the case such payment arrangement does not provide for payment under the fee schedule under section 1848 for such items and services furnished by such eligible professionals, that provides for a payment adjustment based on meaningful EHR use comparable to such adjustment that

would otherwise apply under section 1848; and

"(III) that provides for a payment adjustment based on quality measures comparable to such adjustment that would otherwise apply under section 1848.

"(C) CRITERIA FOR RECOMMENDING MODELS FOR APPROVAL WITHOUT EVALUATION UNDER DEMONSTRATION.—For purposes of subparagraph (A)(ii)(II), the criteria described in this subparagraph, with respect to an Alternative Payment Model, is that the model has already been tested and evaluated for a sufficient enough period and through such testing and evaluation the model was shown—

"(i) to have satisfied the criteria described in each of clauses (i), (ii), (iii), and (v) of subparagraph (B); and

"(ii)(I) to have reduced spending under this title without reducing the quality of care; or

"(II) to have improved the quality of patient care without increasing such spending.

"(D) TRANSPARENCY AND DISCLOSURES.—

"(i) DISCLOSURES.—Not later than 90 days after receipt of a submission of a model under subsection (c) by the APM contracting entity, the APM contracting entity shall submit to the Secretary and the model submitter and make publicly available a notification on whether or not, and if so how, the model meets criteria for recommending such model under subparagraph (A), including whether or not such model requires a waiver under paragraph (2). In the case that the APM contracting entity determines not to recommend such model under this paragraph, such notification shall include an explanation of the reasons for not making such a recommendation. Any information made publicly available pursuant to the previous sentence shall not include proprietary data.

"(ii) SUBMISSION OF RECOMMENDED MODELS.—The APM contracting entity shall at least quarterly submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the

Centers for Medicare & Medicaid Services the following:

"(I) The models recommended under subparagraph (A)(i)(I), including any such models that require a waiver under paragraph (2), and the data and analyses on such recommended models that support the criteria described in subparagraph (B).

"(II) The models recommended under subparagraph (A)(i)(II) and the data and analyses on such recommended models that support the criteria described in subparagraph (C).

"(iii) EXPLANATION FOR NO RECOMMENDATIONS.—For any year beginning with 2015 that the APM contracting entity does not recommend any models under subparagraph (A)(i), the entity shall instead satisfy this clause by submitting to the Secretary and making publicly available an explanation for not having any such recommendations.

"(iv) JUSTIFICATIONS FOR RECOMMENDATIONS.—In submitting data and

analyses under subclause (I) or (II) of clause (ii) with respect to a model, the APM contracting entity shall include a specific explanation of how the model would (and recommendations for ensuring that the model will) meet the criteria described in subparagraph (B) or (C), respectively.

"(v) CONFIRMATION OF SPENDING ESTIMATES BY CMS CHIEF ACTUARY.—For each Alternative Payment Model described in subclause (I) or (II) of clause (ii), the Chief Actuary of the Centers for Medicare & Medicaid Services shall submit to the Secretary a determination of whether or not the Chief Actuary confirms that the model satisfies the criterion described in subparagraph (B)(iv)(I) or (C)(ii), respectively.

"(2) MODELS REQUIRING WAIVER APPROVAL.—

"(A) IN GENERAL.—In the case that an Alternative Payment Model recommended under paragraph (1)(A)(i) would require a waiver from any requirement under this title, in determining approval of such model, the Secretary may make such a waiver solely in order for such

model to be tested and evaluated under the demonstration program.

"(B) APPROVAL.—Not later than 180 days after the date of the receipt of such submission for a model, the Secretary shall notify the APM contracting entity and the entity submitting such model under subsection (c) whether or not such a waiver for such model is approved and the reason for any denial of such a waiver.

"(e) DEMONSTRATION.—

"(1) IN GENERAL.—Subject to paragraphs (5), (6), and (7), the Secretary may conduct a demonstration program, with respect to an Alternative Payment Model approved under paragraph (2), under which participating APM providers shall be paid under this title in accordance with the payment arrangement under such model and such model shall be evaluated by the independent evaluation entity under paragraph (4). The duration of a demonstration program under this subsection, with respect to such a model, shall be 3 years.

"(2) APPROVAL BY SECRETARY OF MODELS FOR DEMONSTRATION.—

"(A) IN GENERAL.—Not later than 180 days after the date of receipt of a submission

under subsection (d)(1)(D)(ii), with respect to an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I), the Secretary shall—

"(i) review the basis for such recommendation in order to assess, taking into account the determination of the Chief Actuary under subsection (d)(1)(D)(v) with respect to such model, if the model is significantly likely to—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of care without increasing spending under this title;

"(ii) assess whether the model is significantly likely to result in participation under such model of a sufficient number of those eligible professionals for whom the model was designed consistent with clause (i) to be able to evaluate the likely effect of expanding the demonstration; and

"(iii) approve such model for a demonstration program under this subsection,

including as modified under subparagraph (B), only if the Secretary determines—

"(I) the model is significantly likely to satisfy the criterion described in subclause (I) or (II) of clause (i);

"(II) the model is significantly likely to result in the participation of a sufficient number of eligible professionals described in clause (ii);

"(III) the model applies rules of coordination described in subparagraph (C) applicable to such model; and

"(IV) the model satisfies the criteria described in subsection (d)(1)(B).

The Secretary shall periodically make available a list of such models approved under clause (iii).

"(B) MODIFICATIONS BY SECRETARY.—

"(i) BEFORE APPROVAL.—For purposes of subparagraph (A), the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I) to ensure that the model meets the requirements described in sub-

paragraph (A)(iii). Such a modification may include one or more of the following:

"(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

"(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

"(III) A change to the rules of coordination described in subparagraph (C).

"(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

"(V) Such other change as the Secretary may specify.

"(ii) TERMINATION OR MODIFICATION DURING DEMONSTRATION.—The Secretary

shall terminate or modify the design and implementation of an Alternative Payment Model approved under subparagraph (A)(iii) for a demonstration program, after testing has begun, unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under this title, certifies) that the model is expected to continue to satisfy the requirements described in such paragraph relating to quality of care and reduced spending. Such termination may occur at any time after such testing has begun and before completion of the testing.

"(C) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(i) IN GENERAL.—Rules of coordination described in this subparagraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible profes-

sional is treated as having a payment arrangement under a particular model.

"(ii) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

"(iii) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

"(3) PARTICIPATING APM PROVIDERS.—

"(A) IN GENERAL.—To participate under a demonstration program under this subsection, with respect to an Alternative Payment Model, an eligible professional shall enter into a contract with the Administrator of the Centers for Medicare & Medicaid Services under this subsection. For purposes of this section, such an eligible professional who so participates under such

an Alternative Payment Model in this section is referred to as a 'participating APM provider'.

"(B) REQUIREMENTS.—The Secretary shall establish criteria for eligible professionals to enter into contracts under this paragraph for purposes of participation under a demonstration program with respect to an Alternative Payment Model. Such criteria shall ensure participation under such model of a sufficient number of eligible professionals for whom the model was designed in order to satisfy the criterion described in paragraph (2)(A)(iii)(II).

"(4) REPORTING AND EVALUATION.—

"(A) INDEPENDENT EVALUATION ENTITY.—Under this subsection, the Secretary shall enter into a contract with an independent entity to evaluate Alternative Payment Models under demonstration programs under this subsection based on appropriate measures specified under subparagraph (B). In this section, such entity shall be referred to as the 'independent evaluation entity'. Such contract shall be entered into in a timely manner so as to ensure evaluation of an Alternative Payment Model under a demonstration program under this subsection may begin as

soon as possible after the model is approved under paragraph (2).

"(B) PERFORMANCE MEASURES.—For purposes of this subsection, the Secretary shall specify—

"(i) measures to evaluate Alternative Payment Models under demonstration programs under this subsection, which may include measures suggested under subsection (c) and shall be sufficient to allow for a comprehensive assessment of such a model; and

"(ii) quality measures on which participating APM providers shall report, which shall be similar to measures applicable under section 1848(k).

"(C) REPORTING REQUIREMENTS.—A contract entered into with a participating APM provider under paragraph (3) shall require such provider to report on appropriate measures specified under subparagraph (B).

"(D) PERIODIC REVIEW.—The independent evaluation entity shall periodically review and analyze and submit such analysis to the Secretary and the participating APM providers in-

volved data reported under subparagraph (C) and such other data as deemed necessary to evaluate the model.

"(E) FINAL EVALUATION.—Not later than 6 months after the date of completion of a demonstration program, the independent evaluation entity shall submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services (and make publicly available) a report on each model evaluated under such program. Such report shall include—

"(i) outcomes on the clinical and claims data received through such program with respect to such model;

"(ii) recommendations on—

"(I) whether or not such model should be implemented as an eligible APM under this section; or

"(II) whether or not the evaluation of such model under the demonstration program should be extended or expanded;

"(iii) the justification for each such recommendation described in clause (ii); and

"(iv) in the case of a recommendation to implement such model as an eligible APM, recommendations on standardized rules for purposes of such implementation.

"(5) APPROVAL OF EXTENDING EVALUATION UNDER DEMONSTRATION.—Not later than 90 days after the date of receipt of a submission under paragraph (4)(E), the Secretary shall, including based on a recommendation submitted under such paragraph, determine whether an Alternative Payment Model may be extended or expanded under the demonstration program.

"(6) TERMINATION.—The Secretary shall terminate a demonstration program for a model under this subsection unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies), after testing has begun, that the model is expected to—

"(A) improve the quality of care (as determined by the Administrator of the Centers for

Medicare & Medicaid Services) without increasing spending under this title;

"(B) reduce spending under this title without reducing the quality of care; or

"(C) 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.

"(7) FUNDING.—

"(A) IN GENERAL.—There are appropriated, from amounts in the Federal Supplementary Medical Insurance Trust Fund under section 1841 not otherwise appropriated and as of the date of the enactment of this section, $2,000,000,000 for the purposes described in subparagraph (B), of which no more than 2.5 percent may be used for the purpose described in clause (iii) of such subparagraph. Amounts appropriated under this subparagraph shall be available until expended.

"(B) PURPOSES.—Amounts appropriated under subparagraph (A) shall be used for—

"(i) payments for items and services furnished by participating APM providers under an Alternative Payment Model under

a demonstration program under this subsection that—

"(I) would not otherwise be eligible for payment under this title; or

"(II) exceed the amount of payment that would otherwise be made for such items and services under this title if such items and services were not furnished under such demonstration program;

"(ii) the evaluations provided for under this section of models under such a demonstration program;

"(iii) payment to the APM contracting entity for carrying out its duties under this section; and

"(iv) for otherwise carrying out this subsection.

"(C) LIMITATION.—The amounts appropriated under subparagraph (A) are the only amounts authorized or appropriated to carry out the purposes described in subparagraph (B).

"(f) IMPLEMENTATION OF RECOMMENDED MODELS AS ELIGIBLE APMS.—

"(1) ASSESSMENT.—With respect to each Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I), the Secretary shall review the basis for such recommendation and assess and determine, in consultation with the Chief Actuary of the Centers for Medicare & Medicaid Services, whether the model is significantly likely to continue to result in meeting the criterion described in subsection (e)(2)(A)(iii)(I), with or without a modification described in paragraph (5).

"(2) IMPLEMENTATION THROUGH RULEMAKING.—

"(A) PUBLICATION OF NPRM.—If the Secretary determines that such a model is significantly likely to meet such criterion, the Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a notice of proposed rulemaking to implement such model, including as modified under paragraph (5).

"(B) COMMENTS BY MEDPAC.—Not later than 90 days after the date of issuance of such notice with respect to a model, the Medicare Payment Advisory Commission shall submit comments on the proposed rule for such model to

Congress and to the Secretary. Such comments shall include an evaluation of the reports from the contracting entity and independent evaluation entity on such model regarding the model's impact on expenditures and quality of care under this title.

"(C) FINAL RULE AND CONDITIONS.—The Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a final notice implementing such proposed rule, including as modified under paragraph (5), as an eligible APM only if—

"(i) the Secretary determines that such model is expected to—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of patient care without increasing spending;

"(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such model would reduce (or would not result in any increase in) spending under this title;

"(iii) the Secretary determines that such model would not deny or limit the coverage or provision of benefits under this title for applicable individuals;

"(iv) the Secretary determines that the model is significantly likely to result in the participation of a sufficient number of appropriate eligible professionals for whom the model was designed in order to satisfy the criterion described in subsection (d)(2)(A)(iii)(II);

"(v) the Secretary determines that the model applies rules of coordination described in paragraph (6); and

"(vi) the Secretary determines that model meets such other criteria as the Secretary may determine.

"(3) APPLICABLE PHYSICIAN FEE SCHEDULE RULEMAKING PROCESS.—For purposes of paragraph (2), in the case of an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I)—

"(A) on or before April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1

of that year of the fee schedule amounts under this section for the succeeding year; or

"(B) after April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of the following year of the fee schedule amounts under this section for the second succeeding year.

"(4) JUSTIFICATION FOR DISAPPROVALS.—In the case that an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I) is not implemented as an eligible APM under this subsection, the Secretary shall make publicly available the rational, in detail, for such decision.

"(5) MODIFICATIONS BY SECRETARY.—For purposes of this subsection, the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I) to ensure that the model meets the requirements under paragraph (1)(B). Such a modification may include one or more of the following:

"(A) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

"(B) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

"(C) A change to the rules of coordination described in paragraph (6).

"(D) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

"(E) Such other change as the Secretary may specify.

"(6) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(A) IN GENERAL.—Rules of coordination described in this paragraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

"(B) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that

might be covered under more than one payment arrangement or under section 1848(d)(16).

"(C) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

"(g) PERIODIC REVIEW AND TERMINATION.—

"(1) PERIODIC REVIEW.—In the case of an Alternative Payment Model that has been implemented, the Secretary and the Chief Actuary of the Centers for Medicare & Medicaid Services shall review such model every 3 years to determine (and certify, in the case of the Chief Actuary and spending under this title), for the previous 3 years, whether the model has—

"(A) reduced the quality of care, or

"(B) increased spending under this title,

compared to the quality of care or spending that would have resulted if the model had not been implemented.

"(2) TERMINATION.—

"(A) QUALITY OF CARE REDUCTION TERMINATION.—If based upon such review the Secretary determines under paragraph (1)(A) that the model has reduced the quality of care, the Secretary may terminate such model.

"(B) SPENDING INCREASE TERMINATION.—Unless such Chief Actuary certifies under paragraph (1)(B) that the expenditures under this title under the model do not exceed the expenditures that would otherwise have been made if the model had not been implemented for the period involved, the Secretary shall terminate such model.

"(h) DISSEMINATION OF ELIGIBLE APMS.—Under this section there shall be established a process for specifying, and making publicly available a list of, all eligible APMs, which shall include at least those implemented under subsection (f) and demonstrations carried out with respect to payments under section 1848 through authority in existence as of the day before the date of the enactment of this section. Under such process such list shall be periodically updated and, beginning with January 1, 2015, and annually thereafter, such list shall be published in the Federal Register.".

(2) CONFORMING AMENDMENT.—Section 1848(a)(1) of the Social Security Act (42 U.S.C. 1395w–4(a)(1)) is amended by striking "shall instead" and inserting "shall, subject to section 1848A, instead".

(d) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

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

"(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

"(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

"(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

"(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

"(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

"(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

"(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (de-

scribed in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

"(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

"(I) for 2017, is 5/6; and

"(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

"(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

"(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would

have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

"(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

"(i) The rest-of-State payment locality.

"(ii) Payment locality 3.

"(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.".

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking "The term" and inserting "Except as provided in subsection (e)(6)(D), the term".

(e) RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.—

(1) ELIGIBLE PHYSICIANS REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—Section 1848(c) of the Social Security Act (42 U.S.C.

1395w–4(c)) is amended by adding at the end the following new paragraph:

"(7) PHYSICIAN REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—

"(A) IN GENERAL.—The Secretary shall implement a system for the periodic reporting by physicians of data on the accuracy of relative values under this subsection, such as data relating to service volume and time. Such data shall be submitted in a form and manner specified by the Secretary and shall, as appropriate, incorporate data from existing sources of data, patient scheduling systems, cost accounting systems, and other similar systems.

"(B) IDENTIFICATION OF REPORTING COHORT.—Not later than January 1, 2015, the Secretary shall establish a mechanism for physicians to participate under the reporting system under this paragraph, all of whom shall collectively be referred to under this paragraph as the 'reporting group'. The reporting group shall include physicians across settings that collectively represent a range of specialties and practitioner types, furnish a range of physicians' services, and serve a range of patient populations.

"(C) INCENTIVE TO REPORT.—Under the system under this paragraph, the Secretary may provide for such payments under this part to physicians included in the reporting group as the Secretary determines appropriate to compensate such physicians for reporting data under the system. Such payments shall be provided in such form and manner as specified by the Secretary. In carrying out this subparagraph, reporting by such a physician under this paragraph shall not be treated as the furnishing of physicians' services for purposes of applying this section.

"(D) FUNDING.—To carry out this paragraph (other than with respect to payments made under subparagraph (C)), in addition to funds otherwise appropriated, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of $1,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.".

(2) RELATIVE VALUE ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

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

"(M) ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

"(i) IN GENERAL.—Only with respect to fee schedules established for 2016, 2017, and 2018 (and not for subsequent years), the Secretary shall—

"(I) identify, based on the data reported under paragraph (8) and other relevant data, misvalued services for which adjustments to the relative values established under this paragraph would result in a reduction in expenditures under the fee schedule under this section, with respect to such year, of not more than 1 percent of the projected amount of expenditures under such fee schedule for such year; and

"(II) make such adjustments for each such year so as only to result in such a reduction for such year.

"(ii) NO EFFECT ON SUBSEQUENT YEARS.—A reduction under this subparagraph for a year shall not affect any reduction for any subsequent year.

"(iii) RULE OF CONSTRUCTION RELATING TO UNDERVALUED CODES.—Nothing in this subparagraph shall be construed as preventing the Secretary from increasing the relative values for codes that are undervalued.".

(B) BUDGET NEUTRALITY.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

"(VIII) REDUCTIONS FOR MISVALUED PHYSICIANS' SERVICES.—Reduced expenditures attributable to subparagraph (M) for fiscal years 2016, 2017, and 2018.".

(3) DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—The Secretary of Health and Human Services

shall make publicly available the data used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register, v. 77, n. 222, November 16, 2012, pages 68891-69380 under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

SEC. 3. EXPANDING AVAILABILITY OF MEDICARE DATA.

(a) EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES.—

(1) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning with 2014, notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, a qualified entity may use data received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), for additional non-public analyses (as determined appropriate by the Secretary of Health and Human Services) or provide or sell such data to registered or authorized users and subscribers, including to providers of services and suppliers, for non-public use (including for the purposes of assisting providers of services

and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(2) DEFINITIONS.—In this section:

(A) The term "qualified entity" has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).

(B) The terms "supplier" and "provider of services" have the meanings given such terms in subsections (d) and (u), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

(b) ACCESS TO MEDICARE DATA TO PROVIDERS OF SERVICES AND SUPPLIERS TO FACILITATE DEVELOPMENT OF ALTERNATIVE PAYMENT MODELS AND TO QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Consistent with applicable laws and regulations with respect to privacy and other relevant matters, the Secretary shall provide Medicare claims data (in a form and manner determined to be appropriate) to—

(1) qualified entities, that may share with providers of services and suppliers that are registered or authorized users or subscribers, for non-public use including to facilitate the development of new models of care (including development of Alternate Payment

Models under section 1848A of the Social Security Act, models for small group specialty practices, and care coordination models); and

(2) qualified clinical data registries under section 1848(m)(3)(E)) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)) for purposes of linking such data with clinical outcomes data and performing and disseminating risk-adjusted, scientifically valid analysis and research to support quality improvement or patient safety, provided that any public reporting of identifiable provider data shall only be conducted with prior consent of such provider.

SEC. 4. ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.

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

"(8) ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.—

"(A) IN GENERAL.—In order to promote the coordination of care by an applicable provider (as defined in subparagraph (B)) for individuals with complex chronic care needs who are furnished items and services by multiple physicians

and other suppliers and providers of services, the Secretary shall—

"(i) develop one or more HCPCS codes for complex chronic care management services for individuals with complex chronic care needs; and

"(ii) for such services furnished on or after January 1, 2015, by an applicable provider, make payment (as the Secretary determines to be appropriate) under the fee schedule under this section using such HCPCS codes.

"(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)) or a physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)) who—

"(i) is certified as a medical home (by achieving an accreditation status of level 3 by the National Committee for Quality Assurance);

"(ii) is recognized as a patient-centered specialty practice by the National Committee for Quality Assurance;

"(iii) has received equivalent certification (as determined by the Secretary); or

"(iv) meets such other comparable qualifications as the Secretary determines to be appropriate.

"(C) BUDGET NEUTRALITY.—The budget neutrality provision under subsection (c)(2)(B)(ii)(II) shall apply in establishing the payment under subparagraph (A)(ii).

"(D) SINGLE APPLICABLE PROVIDER PAYMENT.—In carrying out this paragraph, the Secretary shall only make payment to a single applicable provider for complex chronic care management services furnished to an individual.".

SEC. 5. MISCELLANEOUS.

(a) SOLICITATIONS, RECOMMENDATIONS, AND REPORTS.—

(1) SOLICITATION FOR RECOMMENDATIONS ON EPISODES OF CARE DEFINITION.—The Administrator of the Centers for Medicare & Medicaid Services shall request eligible professional organizations (as defined in section 1848(k)(3) of the Social Security Act (42 U.S.C. 1395w–4(k)(3))) and other relevant stakeholders to submit recommendations for defining non-acute related episodes of care for purposes of applying

such definition under subsections (k) and (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and section 1848A of such Act, as added by subsections (b) and (c) of section 2.

(2) SOLICITATION FOR RECOMMENDATIONS ON PROVIDER FEE SCHEDULE PAYMENT BUNDLES.—

(A) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall solicit from eligible professional organizations (as defined in section 1848(k)(3) of the Social Security Act (42 U.S.C. 1395w–4(k)(3))) recommendations for payment bundles for chronic conditions and expensive, high volume services for which payment is made under title XVIII of such Act.

(B) REPORT TO CONGRESS.—Not later than 24 months after the date of the enactment of this Act, the Administrator shall submit to Congress a report on proposals for such payment bundles.

(3) REPORTS ON MODIFIED PFS SYSTEM AND PAYMENT SYSTEM ALTERNATIVES.—

(A) BIANNUAL PROGRESS REPORTS.—Not later than January 15, 2016, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress and post on the

public Internet website of the Centers for Medicare & Medicaid Services a biannual progress report—

(i) on the implementation of paragraph (9) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)), as added by section 2(b)(2), and the quality update incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by section 2(b)(3);

(ii) that includes an evaluation of such paragraph and such quality update incentive program and recommendations with respect to such program and appropriate update mechanisms; and

(iii) on the actions taken to promote and fulfill the identification of eligible APMs under section 1848A of the Social Security Act, as added by section 2(c), for application under such section 1848A.

(B) GAO AND MEDPAC REPORTS.—

(i) GAO REPORT ON INITIAL STAGES OF PROGRAM.—The Comptroller General of the United States shall submit to Congress

a report for 2019 and each subsequent year analyzing the extent to which the system under section 1848(k)(9) of the Social Security Act (42 U.S.C. 1395w–4(k)(9)) and such quality update incentive program under section 1848(q) of the Social Security Act, as added by section 2(b) is successfully satisfying performance objectives, including with respect to—

(I) the process for developing and selecting measures and activities under subsection (k)(9) of section 1848 of such Act (42 U.S.C. 1395w–4);

(II) the process for assessing performance against such measures and activities under subsection (q) of such section; and

(III) the adequacy of the measures and activities so selected.

(ii) EVALUATION BY GAO AND MEDPAC ON IMPLEMENTATION OF QUALITY UPDATE INCENTIVE PROGRAM.—

(I) GAO.—The Comptroller General of the United States shall evaluate the initial phase of the quality update

incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and shall submit to Congress, not later than 2019, a report with recommendations for improving such quality update incentive program.

(II) MEDPAC.—In the course of its March Report to Congress on Medicare payment policy, MedPAC shall analyze the initial phase of such quality update incentive program and make recommendations, as appropriate, for improving such quality update incentive program.

(iii) MEDPAC REPORT ON PAYMENT SYSTEM ALTERNATIVES.—

(I) IN GENERAL.—Not later than June 15, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report that analyzes multiple options for alternative payment models in lieu of section 1848 of the Social Security Act (42 U.S.C. 1395w–4). In analyzing such models, the

Medicare Payment Advisory Commission shall examine at least the following models:

(aa) Accountable care organization payment models.

(bb) Primary care medical home payment models.

(cc) Bundled or episodic payments for certain conditions and services.

(dd) Gainsharing arrangements

(II) ITEMS TO BE INCLUDED.—Such report shall include information on how each recommended new payment model will achieve maximum flexibility to reward high quality, efficient care.

(C) TRACKING EXPENDITURE GROWTH AND ACCESS.—Beginning in 2015, the Chief Actuary of the Centers for Medicare & Medicaid Services shall track expenditure growth and beneficiary access to physicians' services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and shall post on the public Internet website of

the Centers for Medicare & Medicaid Services annual reports on such topics.

(4) REPORT ON CLINICAL DECISION SUPPORT MECHANISMS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the extent to which clinical decision support mechanisms and other provider support tools could be used to further program objectives under section 1848 of the Social Security Act (42 U.S.C. 1395w–4)) and recommendation for how such mechanisms and tools should be so used.

(b) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDER STANDARDS OF CARE.—

(1) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

(2) DEFINITIONS.—For purposes of this subsection:

(A) The term "Federal health care provision" means any provision of the Patient Protec-

tion and Affordable Care Act (Public Law 111–148), title I and subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and titles XVIII and XIX of the Social Security Act.

(B) The term "health care provider" means any individual or entity—

(i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) The term "medical malpractice or medical liability action or claim" means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) The term "State" includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) NO PREEMPTION.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

SEC. 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "SGR Repeal and Medicare Beneficiary Access Act of 2013".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(a) STABILIZING FEE UPDATES.—

(1) REPEAL OF SGR PAYMENT METHODOLOGY.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting "or a subsequent paragraph" after "paragraph (4)"; and

(ii) in paragraph (4)—

(I) in the heading, by inserting "AND ENDING WITH 2013" after "YEARS BEGINNING WITH 2001"; and

(II) in subparagraph (A), by inserting "and ending with 2013" after "a year beginning with 2001"; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting "through 2013" after "of each succeeding year"; and

(ii) in paragraph (2), by inserting "and ending with 2013" after "beginning with 2000".

(2) UPDATE OF RATES FOR 2014 AND SUBSEQUENT YEARS.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraphs:

"(15) UPDATE FOR 2014 THROUGH 2016.—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 through 2016 shall be 0.5 percent.

"(16) UPDATE FOR 2017 THROUGH 2023.—The update to the single conversion factor established in paragraph (1)(C) for each of 2017 through 2023 shall be zero percent.

"(17) UPDATE FOR 2024 AND SUBSEQUENT YEARS.—The update to the single conversion factor established in paragraph (1)(C) for 2024 and each subsequent year shall be—

"(A) for items and services furnished by a qualifying APM partici-

pant (as defined in section 1833(z)(2)) for such year, 2 percent; and

"(B) for other items and services, 1 percent.".

(3) MEDPAC REPORTS.—

(A) INITIAL REPORT.—Not later than July 1, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment is made under section 1848 of the Social Security Act (42 U.S.C. 1395w–4); and

(ii) total utilization and expenditures (and the rate of increase of such utilization and expenditures) under parts A, B, and D of title XVIII of such Act.

Such report shall include a methodology to describe such relationship

and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

(B) FINAL REPORT.—Not later than July 1, 2020, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship described in subparagraph (A), including the results determined from applying the methodology included in the report submitted under such subparagraph.

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PERFORMANCE PROGRAMS WITH NEW VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(A) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section 1848(a)(7)(A) of the Social Secu-

rity Act (42 U.S.C. 1395w–4(a)(7)(A)) is amended—

(i) in clause (i), by striking "or any subsequent payment year" and inserting "or 2016";

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by striking "Subject to clause (iii), for" and inserting "For";

(II) in subclause (I), by adding at the end "and";

(III) in subclause (II), by striking "; and" and inserting a period; and

(IV) by striking subclause (III); and

(iii) by striking clause (iii).

(B) CONTINUATION OF MEANINGFUL USE DETERMINATIONS FOR VBP PROGRAM.—Section 1848(o)(2) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)) is amended—

(i) in subparagraph (A), in the matter preceding clause (i)—

(I) by striking "For purposes of paragraph (1), an" and inserting "An"; and

(II) by inserting ", or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year" after "under such subsection for a year"; and

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

"(D) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—With respect to 2017 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a VBP eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance pe-

riod under subsection (q) for such year.".

(2) QUALITY REPORTING.—

(A) SUNSETTING SEPARATE QUALITY REPORTING INCENTIVES.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking "or any subsequent year" and inserting "or 2016"; and

(ii) in clause (ii)(II), by striking "and each subsequent year".

(B) CONTINUATION OF QUALITY MEASURES AND PROCESSES FOR VBP PROGRAM.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(i) in subsection (k), by adding at the end the following new paragraph:

"(9) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this

subsection for purposes of subsection (q).”; and

(ii) in subsection (m)—

(I) by redesignating the paragraph (7) added by section 10327(a) of Public Law 111-148 as paragraph (8); and

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

“(9) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection for purposes of subsection (q).”.

(3) VALUE-BASED PAYMENTS.—

(A) SUNSETTING SEPARATE VALUE-BASED PAYMENTS.—Clause (iii) of section 1848(p)(4)(B) of the Social Security Act (42 U.S.C. 1395w–4(p)(4)(B)) is amended to read as follows:

“(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services

furnished on or after January 1, 2015, but before January 1, 2017, with respect to specific physicians and groups of physicians the Secretary determines appropriate. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2017.".

(B) CONTINUATION OF VALUE-BASED PAYMENT MODIFIER MEASURES FOR VBP PROGRAM.—Section 1848(p) of the Social Security Act (42 U.S.C. 1395w–4(p)) is amended—

(i) in paragraph (2), by adding at the end the following new subparagraph:

"(C) CONTINUED APPLICATION FOR PURPOSES OF VBP PROGRAM.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q)." ; and

(ii) in paragraph (3), by adding at the end the following:

"With respect to 2017 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).".

(c) VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

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

"(q) VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional value-based performance incentive program (in this subsection referred to as the 'VBP program') under which the Secretary shall—

"(i) develop a methodology for assessing the total performance of

each VBP eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

"(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

"(iii) use such composite performance score of the VBP eligible professional for a performance period for a year to make VBP program incentive payments under paragraph (7) to the professional for the year.

"(B) PROGRAM IMPLEMENTATION.—The VBP program shall apply to payments for items and services furnished on or after January 1, 2017.

"(C) VBP ELIGIBLE PROFESSIONAL DEFINED.—

"(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term 'VBP eligible professional' means—

"(I) for the first and second years for which the VBP program applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

"(II) for the third year for which the VBP program applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each

such year), the professionals described in subclause (I) and such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

"(ii) EXCLUSIONS.—For purposes of clause (i), the term 'VBP eligible professional' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B))—

"(I) who is a qualifying APM participant (as defined in section 1833(z)(2));

"(II) who, subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in

paragraph (2)(B) that are required to be reported by such a professional under the VBP program; or

"(III) who, for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

"(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term 'partial qualifying APM participant' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

"(I) with respect to 2017 and 2018, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

"(II) with respect to 2019 and 2020—

"(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

"(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

"(III) with respect to 2021 and subsequent years—

"(aa) the reference in subparagraph (C)(i) of

such paragraph to 75 percent was instead a reference to 50 percent; and

"(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

"(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select one of the following low-volume threshold measurements to apply for purposes of clause (ii)(III):

"(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the VBP eligible professional for the performance period involved.

"(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

"(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

"(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such profes-

sional shall not be treated under this subsection as a VBP eligible professional until the subsequent year and performance period for such subsequent year.

"(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a VBP eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a reduction under paragraph (6) or a VBP program incentive payment under paragraph (7) apply to such individual for such year.

"(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATION.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who for the performance period for such year reports on applicable measures and activities described in paragraph

(2)(B) that are required to be reported by such a professional under the VBP program, such eligible professional is considered to be a VBP eligible professional with respect to such year.

"(D) APPLICATION TO GROUP PRACTICES.—

"(i) IN GENERAL.—Under the VBP program:

"(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

"(II) OTHER PERFORMANCE CATEGORIES.—The Secretary

may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

"(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the full range of items and services furnished by the VBP eligible professionals in the group practice involved.

"(iii) CLARIFICATION.—VBP eligible professionals electing to be a virtual group under paragraph (5)(J) shall not be considered VBP

eligible professionals in a group practice for purposes of applying this subparagraph.

"(E) USE OF REGISTRIES.—Under the VBP program, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

"(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

"(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

"(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

"(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

"(A) PERFORMANCE CATEGORIES.—Under the VBP program, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

"(i) Quality.

"(ii) Resource use.

"(iii) Clinical practice improvement activities.

"(iv) Meaningful use of certified EHR technology.

"(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

"(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality

measures established for such period under subsections (k) and (m), including under subsection (m)(3)(E), and the measures of quality of care established for such period under subsection (p)(2).

"(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r), as appropriate, and, as feasible and applicable, accounting for the cost of covered part D drugs.

"(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities under subcategories specified by the Secretary for such period,

which shall include at least the following:

"(I) The subcategory of expanded practice access, which shall include activities such as same day appointments for urgent needs and after hours access to clinician advice.

"(II) The subcategory of population management, which shall include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

"(III) The subcategory of care coordination, which shall include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers,

and use of remote monitoring or telehealth.

"(IV) The subcategory of beneficiary engagement, which shall include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management training, and using shared decision-making mechanisms.

"(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

"(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the cir-

cumstances of small practices (consisting of fewer than 20 professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

"(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

"(C) ADDITIONAL PROVISIONS.—

"(i) EMPHASIZING OUTCOME MEASURES UNDER QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

"(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The

Secretary may use measures used for a payment system other than for physicians for purposes of the performance category described in subparagraph (A)(i).

"(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

"(iv) REQUEST FOR INFORMATION FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders for identifying activities described in such subparagraph and specifying criteria for such activities.

"(v) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

"(I) identifying activities described in subparagraph (B)(iii);

"(II) specifying criteria for such activities; and

"(III) determining whether a VBP eligible professional meets such criteria.

"(vi) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROVIDERS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

"(I) shall give consideration to the circumstances of

professional types (or subcategories of those types determined by practice characteristics) who typically provide services that do not involve face-to-face interaction with a patient; and

"(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to VBP eligible professionals of such professional types or subcategories, in lieu of such a measure or activity, a comparable measure or activity that fulfills the goals of the applicable performance category.

In carrying out the previous sentence, the Secretary shall consult with professionals of such professional types or subcategories.

"(3) PERFORMANCE STANDARDS.—

"(A) ESTABLISHMENT.—Under the VBP program, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

"(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall take into account the following:

"(i) Historical performance standards.

"(ii) Improvement rates.

"(iii) The opportunity for continued improvement.

"(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with the year described in paragraph (1)(B)). Such performance period (or periods) shall begin and end prior to the be-

ginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

"(5) COMPOSITE PERFORMANCE SCORE.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (in this subsection

referred to as the 'composite performance score') for each such professional for each performance period.

"(B) WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), the Secretary—

"(i) may assign different scoring weights (including a weight of 0) for—

"(I) each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

"(II) each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable to the type of eligible professional involved; and

"(ii) with respect to the performance category described in paragraph (2)(A)(i)—

"(I) shall assign a higher scoring weight to outcomes measures than to other measures and increase the scoring weight for outcome measures over time; and

"(II) may assign a higher scoring weight to patient experience measures.

"(C) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

"(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a VBP eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional

shall be treated as achieving the lowest potential score applicable to such measure or activity.

"(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

"(I) encourage VBP eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology; and

"(II) with respect to a performance period, with respect to a year, for which a VBP eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting require-

ment described in subsection (o)(2)(A)(iii) for such year.

"(D) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

"(i) RULE FOR ACCREDITATION.—A VBP eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice pursuant to subsection (b)(8)(B)(i) with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

"(ii) APM PARTICIPATION.—Participation by a VBP eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional one-half of the highest potential score for

the performance category described in paragraph (2)(A)(iii) for such performance period. Nothing in the previous sentence shall prevent such professional from earning more than one-half of such highest potential score for such performance period by performing additional activities with respect to such performance category.

"(iii) SUBCATEGORIES.—A VBP eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

"(E) DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in a continuous distribution of performance

scores, which shall result in differential payments under paragraph (7).

"(F) ACHIEVEMENT AND IMPROVEMENT.—

"(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the VBP program applies, in addition to the achievement score of a VBP eligible professional, the methodology developed under subparagraph (A)—

"(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

"(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

"(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Beginning with the fourth year to which the VBP program applies, under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (B) with respect to the achievement score of a VBP eligible professional with respect to a measure or activity specified under paragraph (2)(B) (or with respect to such a measure or activity and with respect to categories described in paragraph (2)(A)) than to any improvement score applied under clause (i) with respect to such measure or activity (or such measure or activity and categories).

"(G) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

"(i) IN GENERAL.—Under the methodology developed under

subparagraph (A), subject to clauses (ii) and (iii), the composite performance score shall be determined as follows:

"(I) QUALITY.—

"(aa) IN GENERAL.—Subject to item (bb), 30 percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A).

"(bb) FIRST 2 YEARS AND TEST YEAR.—For the first and second years for which the VBP program applies to payments, 60 percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). With respect to the subsequent year, the per-

cent described in item (aa) of such score shall be based on performance with respect to such category only for purposes of feedback and 60 percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

"(II) RESOURCE USE.—

"(aa) IN GENERAL.—Subject to item (bb), 30 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

"(bb) FIRST 2 YEARS AND TEST YEAR.—For the first and second years for which the VBP program

applies to payments, zero percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). With respect to the subsequent year, the percent described in item (aa) of such score shall be based on performance with respect to such category only for purposes of feedback and zero percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

"(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the cat-

egory described in clause (iii) of paragraph (2)(A).

"(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

"(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, the percentages applicable under one or more of subclauses

(I), (II), and (III) of clause (i) for such year (or, in the case of a year described in clause (i)(II)(bb), applicable under one or more of subclauses (I) and (III)) shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

"(iii) AUTHORITY TO ADJUST PERCENTAGES FOR QUALITY AND RESOURCE USE.—Other than for a year described in clause (i)(II)(bb), the percentages described in subclauses (I) and (II) of clause (i), including after application of clause (ii), shall be equal.

"(H) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology de-

scribed in subsection (r)(5), as appropriate.

"(I) INCLUSION OF QUALITY MEASURE DATA FROM MULTIPLE PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by VBP eligible professionals with respect to multiple payers.

"(J) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

"(i) IN GENERAL.—In the case of VBP eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A)—

"(I) the assessment of performance provided under such methodology with re-

spect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A) that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

"(II) the composite score provided under this paragraph for such performance period with respect to each such performance category for each such VBP eligible professional in such virtual group shall be based on the assessment of the combined performance under subclause (I) for the performance category and performance period.

"(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Sec-

retary shall, in accordance with clause (iii), establish and have in place a process to allow an individual VBP eligible professional or a group practice consisting of not more than 10 VBP eligible professionals to elect, with respect to a performance period for a year, for such individual VBP eligible professional or all such VBP eligible professionals in such group practice, respectively, to be a virtual group under this subparagraph with at least one other such individual VBP eligible professional or group practice making such an election.

"(iii) REQUIREMENTS.—The process under clause (ii) shall provide that—

"(I) an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and

may not be changed during such performance period; and

"(II) a practice described in such clause, and each VBP eligible professional in such practice, may elect to be in no more than one virtual group for a performance period.

"(6) FUNDING FOR VBP PROGRAM INCENTIVE PAYMENTS.—

"(A) TOTAL AMOUNT FOR INCENTIVE PAYMENTS.—The total amount for VBP program incentive payments under paragraph (7) for all VBP eligible professionals for a year shall be equal to the total amount of the performance funding pool for all VBP eligible professionals under subparagraph (B) for such year, as estimated by the Secretary.

"(B) PERFORMANCE FUNDING POOL.—

"(i) IN GENERAL.—In the case of items and services furnished by a VBP eligible professional during

a year (beginning with 2017), the otherwise applicable fee schedule amount (as defined in clause (iii)) with respect to such items and services and eligible professional for such year shall be reduced by the applicable percent under clause (ii). The total amount of such reductions for a year shall be referred to in this subsection as the 'performance funding pool' for such year.

"(ii) APPLICABLE PERCENT DEFINED.—For purposes of clause (i), the term 'applicable percent' means—

"(I) for 2017, 4 percent;

"(II) for 2018, 6 percent;

"(III) for 2019, 8 percent;

"(IV) for 2020, 10 percent; and

"(V) for 2021 and subsequent years, a percent specified by the Secretary (but in

no case less than 10 percent or more than 12 percent).

"(iii) OTHERWISE APPLICABLE FEE SCHEDULE AMOUNT.—For purposes of this subparagraph and paragraph (7), the term 'otherwise applicable fee schedule amount' means, with respect to items and services furnished by a VBP eligible professional during a year, the fee schedule amount for such items and services and year that would otherwise apply (without application of this subparagraph or paragraph (7)) with respect to such eligible professional under subsection (b), after application of subsection (a)(3), or under another fee schedule under this part.

"(7) VBP PROGRAM INCENTIVE PAYMENTS.—

"(A) VBP PROGRAM INCENTIVE PAYMENT ADJUSTMENT FACTOR.—Consistent with section 2(g)(2) of the SGR

Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall specify a VBP program incentive payment adjustment factor for each VBP eligible professional for a year. Such VBP program incentive payment adjustment factor for a VBP eligible professional for a year shall be determined—

"(i) by the composite performance score of the eligible professional for such year;

"(ii) in a manner such that the adjustment factors specified under this subparagraph for a year results in differential payments under this paragraph reflecting the full range of the distribution of composite performance scores of VBP eligible professionals determined under paragraph (5)(E) for such year, with such professionals having higher composite performance scores receiving higher payment; and

"(iii) in a manner such that the adjustment factors specified under this subparagraph for a year—

"(I) does not result in a payment reduction for such year by an amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year; and

"(II) does not result in a payment increase for such year by an amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year.

"(B) CALCULATION OF VBP PROGRAM INCENTIVE PAYMENT AMOUNTS.—The VBP program incentive payment amount with respect to items and services furnished by a VBP eligible professional during a year shall be equal to the difference between—

"(i) the product of—

"(I) the VBP program incentive payment adjustment factor determined under subparagraph (A) for such VBP eligible professional for such year; and

"(II) the otherwise applicable fee schedule amount (as defined in paragraph (6)(B)(iii)) with respect to such items and services and eligible professional for such year; and

"(ii) the otherwise applicable fee schedule amount, as reduced under paragraph (6)(B), with respect to such items and services, eligible professional, and year.

The application of the preceding sentence may result in the VBP program incentive payment amount being 0.0 with respect to an item or service furnished by a VBP eligible professional.

"(C) APPLICATION OF VBP PROGRAM INCENTIVE PAYMENT AMOUNT.—In the

case of items and services furnished by a VBP eligible professional during a year (beginning with 2017), the otherwise applicable fee schedule amount, as reduced under paragraph (6)(B), with respect to such items and services and eligible professional for such year shall be increased, if applicable, by the VBP program incentive payment amount determined under subparagraph (B) with respect to such items and services, professional, and year.

"(D) BUDGET NEUTRALITY.—In specifying the VBP program incentive payment adjustment factor for each VBP eligible professional for a year under subparagraph (A), the Secretary shall ensure that the total amount of VBP program incentive payment amounts under this paragraph for all VBP eligible professionals in a year shall be equal to the performance funding pool for such

year under paragraph (6), as estimated by the Secretary.

"(8) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the VBP program, the Secretary shall, not later than 60 days prior to the year involved, make available to each VBP eligible professional the VBP program incentive payment adjustment factor under paragraph (7) and the payment reduction under paragraph (6) applicable to the eligible professional for items and services furnished by the professional in such year. The Secretary may include such information in the confidential feedback under paragraph (13).

"(9) NO EFFECT IN SUBSEQUENT YEARS.—The VBP program incentive payment under paragraph (7) and the payment reduction under paragraph (6) shall each apply only with respect to the year involved, and the Secretary shall not take into account such VBP program incentive payment or payment reduction in making payments to a VBP eligible professional under this part in a subsequent year.

"(10) PUBLIC REPORTING.—

"(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website under subsection (t) the following:

"(i) Information regarding the performance of VBP eligible professionals under the VBP program, which—

"(I) shall include the composite score for each such VBP eligible professional and the performance of each such VBP eligible professional with respect to each performance category; and

"(II) may include the performance of each such VBP eligible professional with respect to each measure or activity specified in paragraph (2)(B).

"(ii) The names of eligible professionals in eligible alternative

payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

"(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph

prior to such information being made public.

"(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the VBP program, including the range of composite scores for all VBP eligible professionals and the range of the performance of all VBP eligible professionals with respect to each performance category.

"(11) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the VBP program, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (7). Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

"(12) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

"(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to VBP eligible professionals in practices of fewer than 20 professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of the Public Health Service Act), or practices with low composite scores) with respect to—

"(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

"(ii) how to transition to the implementation of and participation in an alternative payment

model as described in section 1833(z)(3)(C).

"(B) FUNDING FOR IMPLEMENTATION.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $50,000,000 for each of fiscal years 2014 through 2018. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

"(13) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

"(A) PERFORMANCE FEEDBACK.—

"(i) IN GENERAL.—Beginning July 1, 2015, the Secretary—

"(I) shall make available timely (such as quarterly) confidential feedback to each VBP eligible professional on the performance of such pro-

fessional with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

"(II) may make available confidential feedback to each such professional on the performance of such professional with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

"(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. The Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

"(iii) USE OF DATA.—For purposes of clause (i), the Secretary

may use data, with respect to a VBP eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

"(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

"(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive information from professionals, such as information with respect to this subsection.

"(B) ADDITIONAL INFORMATION.—

"(i) IN GENERAL.—Beginning July 1, 2016, the Secretary shall make available to each VBP eligible professional information, with

respect to individuals who are patients of such VBP eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information shall be made available under the previous sentence to such VBP eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information shall be made available in accordance with the same or similar terms as data are made available to accountable care organizations under section 1899, including a beneficiary opt-out.

"(ii) TYPE OF INFORMATION.—For purposes of clause (i), the in-

formation described in this clause, is the following:

"(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a VBP eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

"(II) Historical averages (and other measures of the

distribution if appropriate) of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary) for care episodes for such period.

"(14) REVIEW.—

"(A) TARGETED REVIEW.—The Secretary shall establish a process under which a VBP eligible professional may seek an informal review of the calculation of the VBP program incentive payment adjustment factor applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (7) with respect to a year (other than with respect to the calculation of such eligible professional's VBP program incentive payment adjustment factor for such year) after the factors determined in subparagraph (A) of such

paragraph have been determined for such year.

"(B) LIMITATION.—Except as provided for 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 VBP program incentive payment adjustment factor under paragraph (7) and the determination of such amount.

"(ii) The determination of the amount of funding available for such VBP program incentive payments under paragraph (6)(A) and the payment reduction under paragraph (6)(B)(i).

"(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

"(iv) The identification of measures and activities specified

under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (10).

"(v) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.".

(2) GAO REPORTS.—

(A) EVALUATION OF ELIGIBLE PROFESSIONAL VBP PROGRAM.—Not later than October 1, 2018, and October 1, 2021, the Comptroller General of the United States shall submit to Congress a report evaluating the eligible professional value-based performance incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1). Such report shall—

(i) examine the distribution of the performance and incentive payments for VBP eligible professionals (as defined in subsection (q)(1)(C) of such section) under such program, and patterns relating to such performance and incentive payments, including based on type of provider, practice size, geographic location, and patient mix; and

(ii) provide recommendations for improving such program.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that—

(i) compares the similarities and differences in the use of quality measures under the original medicare fee-for-service program

under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, and private payer arrangements; and

(ii) makes recommendations on how to reduce the administrative burden involved in applying such quality measures.

(3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of $50,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2014 through 2017. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

(A) IN GENERAL.—Section 1848(m)(3)(C)(ii)) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended by inserting "and, for 2014 and subsequent years, may provide" after "shall provide".

(B) CLARIFICATION OF QUALIFIED CLINICAL DATA REGISTRY REPORTING TO GROUP PRACTICES.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting "and, for 2015 and subsequent years, subparagraph (A) or (C)" after "subparagraph (A)".

(2) CHANGES FOR MULTIPLE REPORTING PERIODS AND ALTERNATIVE CRITERIA FOR SATISFACTORY REPORTING.—Section 1848(m)(5)(F)) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)(F)) is amended—

(A) by striking "and subsequent years" and inserting "through reporting periods occurring in 2013"; and

(B) by inserting "and, for reporting periods occurring in 2014 and subsequent years, the Secretary may establish" following "shall establish".

(3) PHYSICIAN FEEDBACK PROGRAM REPORTS SUCCEEDED BY REPORTS UNDER VBP PROGRAM.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended by adding at the end the following new paragraph:

"(11) REPORTS ENDING WITH 2016.—Reports under the Program shall not be provided after December 31, 2016. See subsection (q)(13) for reports beginning with 2017.".

(4) COORDINATION WITH SATISFYING MEANINGFUL EHR USE CLINICAL QUALITY MEASURE REPORTING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(iii)) is amended by inserting "and subsection (q)(5)(C)(ii)(II)" after "Subject to subparagraph (B)(ii)".

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

(1) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

"(1) PAYMENT INCENTIVE.—

"(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2017 and ending with 2022 and for which the professional is a qualifying APM participant, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the payment amount for the covered professional services under this part for the

preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases where payment for covered professional services furnished by a qualifying APM participant in an alternative payment model is made to an entity participating in the alternative payment model rather than directly to the qualifying APM participant.

"(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

"(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alter-

native payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

"(D) COORDINATION.—The amount of the additional payment for an item or service under this subsection or subsection (m) shall be determined without regard to any additional payment for the item or service under subsection (m) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (x) shall be determined without regard to any additional payment for the item or service under subsection (x) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (y) shall be determined without regard to any additional payment for the item or service under subsection (y) and this subsection, respectively.

"(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term 'qualifying APM participant' means the following:

"(A) 2017 AND 2018.—With respect to 2017 and 2018, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

"(B) 2019 AND 2020.—With respect to 2019 and 2020, an eligible professional described in either of the following clauses:

"(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Sec-

retary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

"(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

"(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less

than a year), that at least 50 percent of the sum of—

"(aa) payments described in clause (i); and

"(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

"(II) for whom the Secretary determines at least 25 percent of payments under

this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

"(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

"(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

"(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made

under an eligible alternative payment model; and

"(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

"(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

"(bb) certified EHR technology is used; and

"(cc) the eligible professional bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures.

"(C) BEGINNING IN 2021.—With respect to 2021 and each subsequent year, an eligible professional de-

scribed in either of the following clauses:

"(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

"(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

"(I) for whom the Secretary determines, with respect to items and services

furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

"(aa) payments described in clause (i); and

"(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause

(iii)(II) with respect to payments described in item (bb);

"(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

"(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

"(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

"(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

"(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

"(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

"(bb) certified EHR technology is used; and

"(cc) the eligible professional bears more than nominal financial risk if actual aggregate expendi-

tures exceeds expected aggregate expenditures.

"(2) ADDITIONAL DEFINITIONS.—In this subsection:

"(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given that term in section 1848(k)(3)(A).

"(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given that term in section 1848(k)(3)(B).

"(C) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means any of the following:

"(i) A model under section 1115A (other than a health care innovation award).

"(ii) An accountable care organization under section 1899.

"(iii) A demonstration under section 1866C.

"(iv) A demonstration required by Federal law.

"(D) ELIGIBLE ALTERNATIVE PAYMENT MODEL (APM).—

"(i) IN GENERAL.—The term 'eligible alternative payment model' means, with respect to a year, an alternative payment model—

"(I) that requires use of certified EHR technology (as defined in subsection (o)(4));

"(II) that provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

"(III) that satisfies the requirement described in clause (ii).

"(ii) ADDITIONAL REQUIREMENT.—For purposes of clause (i)(III), the requirement described in this clause, with respect to a year and an alternative payment

model, is that the alternative payment model—

"(I) is one in which one or more entities bear financial risk for monetary losses under such model that are in excess of a nominal amount; or

"(II) is a medical home expanded under section 1115A(c).

"(3) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

"(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an alternative payment model is an eligible alternative payment model under paragraph (3)(D).

"(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), in-

cluding any estimation as part of such determination.".

(2) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended—

(A) in subsection (x)(3), by adding at the end the following new sentence: "The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively."; and

(B) in subsection (y)(3), by adding at the end the following new sentence: "The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.".

(3) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.—Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

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

"(xxi) Focusing primarily on physicians' services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

"(xxii) Focusing on practices of fewer than 20 professionals."; and

(B) in subparagraph (C)(viii), by striking "other public sector or private sector payers" and inserting "other public sector payers, private sector payers, or Statewide payment models".

(f) STUDY AND REPORT ON FRAUD RELATED TO ALTERNATIVE PAYMENT MODELS UNDER THE MEDICARE PROGRAM.—

(1) STUDY.—The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

(A) examines the applicability of the Federal fraud prevention laws to items and services furnished under title XVIII of the Social Security Act for which payment is made under an alternative payment model (as defined in section 1833(z)(3)(C) of such Act (42 U.S.C. 1395l(z)(3)(C)));

(B) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(C) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of

the study conducted under paragraph (1). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

(g) IMPROVING PAYMENT ACCURACY.—

(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE .—

(A) STUDY USING EXISTING MEDICARE DATA.—

(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program (such as to recognize that less healthy indi-

viduals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

(ii) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

(B) STUDY USING OTHER DATA.—

(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors,

such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and patient activation, on quality and resource use outcome measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what

non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality and resource use outcome measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

(i) obtain access to the necessary data (if such data is not already being collected) on such

factors, including recommendations on how to address barriers to the Centers in accessing such data; and

(ii) account for such factors in determining payment adjustments based on quality and resource use outcome measures under the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)) and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(E) FUNDING.—There are hereby appropriated from the Federal Supplemental Medical Insurance Trust Fund to the Secretary to carry out this paragraph $6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) HIERARCHAL CONDITION CATEGORY (HCC) IMPROVEMENT.—Taking

into account the relevant studies conducted and recommendations made in reports under paragraph (1), the Secretary, on an ongoing basis, shall estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(B) ACCOUNTING FOR OTHER FACTORS IN PAYMENT ADJUSTMENT MECHANISMS.—

(i) IN GENERAL.—Taking into account the studies conducted and recommendations made in reports under paragraph (1), the

Secretary shall account for identified factors (other than those applied under subparagraph (A)) with an effect on quality and resource use outcome measures when determining payment adjustments under the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(ii) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

(iii) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in

clause (i) so as to monitor changes in possible relationships.

(C) FUNDING.—There are hereby appropriated from the Federal Supplemental Medical Insurance Trust Fund to the Secretary to carry out this paragraph $10,000,000, to remain available until expended.

(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of carrying out the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(h) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—Section 1848 of the Social Security Act

(42 U.S.C. 1395w–4), as amended by subsection (c), is further amended by adding at the end the following new subsection:

"(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

"(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the value-based performance incentive program under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

"(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

"(A) IN GENERAL.—In order to classify similar patients into distinct care episode groups and distinct patient condition groups, the Secretary shall

undertake the steps described in the succeeding provisions of this paragraph.

"(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 60 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

"(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 60 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

"(i) distinct care episode groups; and

"(ii) distinct patient condition groups.

"(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

"(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

"(I) establish distinct care episode groups and distinct patient condition groups, which account for at least an estimated two-thirds of expenditures under parts A and B; and

"(II) assign codes to such groups.

"(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and

"(II) other factors determined appropriate by the Secretary.

"(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant his-

tory (such as hospitalization and major surgery during a previous period, such as 3 months); and

"(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

"(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 120 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

"(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

"(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 120 days after the end of the comment period described in subparagraph (F), taking into account the

comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

"(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

"(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

"(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

"(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a

physician or applicable practitioner who—

"(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

"(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

"(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

"(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

"(v) furnishes items and services only as ordered by another physician or practitioner.

"(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

"(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under sub-

paragraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

"(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 120 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

"(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as

the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

"(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2016, shall, as determined appropriate by the Secretary, include—

"(A) applicable codes established under paragraphs (2) and (3); and

"(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

"(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

"(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall—

"(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

"(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

"(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

"(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

"(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

"(ii) use the claims data experience of such patients by care episode codes—

"(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

"(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before,

during, and after the hospitalization.

"(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

"(i) shall use per patient total allowed amounts for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

"(ii) may, as determined appropriate, use other measures of allowed amounts (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

"(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from

the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

"(6) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

"(A) care episode and patient condition groups and codes established under paragraph (2);

"(B) patient relationship categories and codes established under paragraph (3); and

"(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

"(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

"(8) DEFINITIONS.—In this section:

"(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

"(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

"(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)); and

"(ii) beginning January 1, 2017, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

"(9) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.".

SEC. 3. PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (h) of section 2, is further amended by inserting at the end the following new subsection:

"(s) PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.—

"(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

"(A) DRAFT MEASURE DEVELOPMENT PLAN.—

"(i) DRAFT PLAN.—

"(I) IN GENERAL.—Not later than October 1, 2014, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application

under the applicable provisions.

"(II) REQUIREMENT.—Such plan shall address how measures used by private payers and integrated delivery systems could be incorporated under such subsection.

"(ii) CONSIDERATION.—In developing the draft plan under subparagraph (A), the Secretary shall consider—

"(I) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities; and

"(II) whether measures are applicable across health care settings.

"(iii) PRIORITIES.—In developing the draft plan under subparagraph (A), the Secretary shall give priority to the following types of measures:

"(I) Outcome measures including patient reported outcome and functional status measures.

"(II) Patient experience measures.

"(III) Care coordination measures.

"(IV) Measures of appropriate use of services, including measures of over use.

"(iv) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term 'applicable provisions' means the following provisions:

"(I) Subsection (q)(2)(B)(i).

"(II) Section 1833(z)(2)(C).

"(B) STAKEHOLDER INPUT.—The Secretary shall accept through December 1, 2014, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

"(C) OPERATIONAL MEASURE DEVELOPMENT PLAN.—Not later than February 1, 2015, taking into account the comments received under subparagraph (B), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under subsection (q)(2)(A)(i).

"(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

"(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding quality measures for application under the applicable provisions. Such entities may include physician specialty societies and other practitioner organizations.

"(B) PRIORITIZATION.—

"(i) IN GENERAL.—In entering into contracts or other arrange-

ments under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(A)(iii).

"(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider whether such measures would be electronically specified.

"(3) ANNUAL REPORT BY THE SECRETARY.—

"(A) IN GENERAL.—Not later than February 1, 2016, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

"(B) REQUIREMENTS.—Each report submitted pursuant to paragraph (1) shall include the following:

"(i) A description of the Secretary's efforts to implement this subsection.

"(ii) With respect to the measures developed during the previous year—

"(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

"(II) the name of each measure developed;

"(III) the name of the developer and steward of each measure;

"(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

"(V) whether the measure would be electronically specified.

"(iii) With respect to measures in development at the time of the report—

"(I) the information described in clause (ii), if available; and

"(II) a timeline for completion of the development of such measures.

"(iv) An update on the progress in developing the types of measures described in paragraph (1)(A)(iii), including a description of issues affecting such progress.

"(v) A list of quality topics and concepts that are being considered for development of measures and the rationale for the selection of topics and concepts including their relationship to gap analyses.

"(vi) A description of any updates to the plan under paragraph (1) (including newly identi-

fied gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

"(vii) Other information the Secretary determines to be appropriate.

"(4) STAKEHOLDER INPUT.—With respect to measures applicable under the applicable provisions, the Secretary shall seek stakeholder input with respect to—

"(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(A)(iii);

"(B) prioritizing quality measure development to address such gaps; and

"(C) other areas related to quality measure development determined appropriate by the Secretary.

"(5) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the

Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2021.".

SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.

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

"(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

"(A) IN GENERAL.—In order to encourage the management of care by an applicable provider (as defined in subparagraph (B)) for individuals with chronic care needs the Secretary shall—

"(i) establish one or more HCPCS codes for chronic care

management services for such individuals; and

"(ii) subject to subparagraph (D), make payment (as the Secretary determines to be appropriate) under this section for such management services furnished on or after January 1, 2015, by an applicable provider.

"(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), or clinical nurse specialist (as defined in section 1861(aa)(5)(B)) who furnishes services as part of a patient-centered medical home or a comparable specialty practice that—

"(i) is recognized as such a medical home or comparable specialty practice by an organization that is recognized by the Sec-

retary for purposes of such recognition as such a medical home or practice; or

"(ii) meets such other comparable qualifications as the Secretary determines to be appropriate.

"(C) BUDGET NEUTRALITY.—The budget neutrality provision under subsection (c)(2)(B)(ii)(II) shall apply in establishing the payment under subparagraph (A)(ii).

"(D) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

"(i) make payment to only one applicable provider for such services furnished to an individual during a period;

"(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this

title for such services (such as in the case of hospice care or home health services); and

"(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.".

SEC. 5. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

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

"(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

"(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

"(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

"(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may,

at the Secretary's discretion, include any or all of the following:

"(I) Time involved in furnishing services.

"(II) Amounts and types of practice expense inputs involved with furnishing services.

"(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

"(IV) Overhead and accounting information for practices of physicians and other suppliers.

"(V) Any other element that would improve the valuation of services under this section.

"(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to

this subparagraph from any or all of the following:

"(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

"(II) Surgical logs, billing systems, or other practice or facility records.

"(III) Electronic health records.

"(IV) Any other mechanism determined appropriate by the Secretary.

"(v) TRANSPARENCY OF USE OF INFORMATION.—

"(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and

discuss the use of such information in such determination of relative values through notice and comment rulemaking.

"(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

"(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information col-

lected or obtained pursuant to a nondisclosure agreement.

"(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

"(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

"(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term 'eligible professional' has the meaning given such term in subsection (k)(3)(B).

"(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.".

(2) LIMITATION ON REVIEW.—Section 1848(i)(1) of the Social Security Act (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking "and" at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ", and"; and

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

"(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).".

(b) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

"(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).".

(c) REVISED AND EXPANDED IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—Section

1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(K)(ii)) is amended to read as follows:

"(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

"(I) Codes that have experienced the fastest growth.

"(II) Codes that have experienced substantial changes in practice expenses.

"(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

"(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

"(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

"(VI) Codes that have not been subject to review since implementation of the fee schedule.

"(VII) Codes that account for the majority of spending under the physician fee schedule.

"(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

"(IX) Codes for which there may be a change in the

typical site of service since the code was last valued.

"(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

"(XI) Codes for which there may be anomalies in relative values within a family of codes.

"(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

"(XIII) Codes with high intra-service work per unit of time.

"(XIV) Codes with high practice expense relative value units.

"(XV) Codes with high cost supplies.

"(XVI) Codes as determined appropriate by the Secretary.".

(d) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

"(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2015 through 2018, the following shall apply:

"(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

"(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

"(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

"(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been

met under this subparagraph with respect to that year.

"(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2015.

"(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

"(I) the target for the year; and

"(II) the estimated net reduction in expenditures deter-

mined under clause (i) for the year.

"(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.".

(2) CONFORMING AMENDMENT.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

"(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2015, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).".

(e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—

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

"(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2015, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.".

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

(A) in subparagraph (B)(ii)(I), by striking "subclause (II)" and inserting "subclause (II) and paragraph (7)"; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking "provisions of subparagraph (B)(ii)(II)" and inserting "provisions of subparagraph (B)(ii)(II) and paragraph (7)"; and

(ii) by striking "under subparagraph (B)(ii)(II)" and inserting "under subparagraph (B)(ii)(I)".

(f) AUTHORITY TO SMOOTH RELATIVE VALUES WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)) is amended—

(1) in each of clauses (i) and (iii), by striking "the service" and inserting "the service or group of services" each place it appears; and

(2) in the first sentence of clause (ii), by inserting "or group of services" before the period.

(g) GAO STUDY AND REPORT ON RELATIVE VALUE SCALE UPDATE COMMITTEE.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the "Comptroller General")

shall conduct a study of the processes used by the Relative Value Scale Update Committee (RUC) to provide recommendations to the Secretary of Health and Human Services regarding relative values for specific services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1).

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

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

"(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this para-

graph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

"(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

"(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

"(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

"(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in sub-

paragraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

"(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

"(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year

(determined without regard to this subparagraph).

"(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

"(I) for 2017, is 5/6; and

"(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

"(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

"(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied

in such transition area (as estimated by the Secretary) if this paragraph did not apply.

"(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

"(i) The rest-of-State payment locality.

"(ii) Payment locality 3.

"(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.".

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking "The term" and inserting "Except as provided in subsection (e)(6)(D), the term".

SEC. 6. PROMOTING EVIDENCE-BASED CARE.

(a) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

"(1) PROGRAM ESTABLISHED.—

"(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

"(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term 'appropriate use criteria' means criteria to assist ordering professionals and furnishing professionals in mak-

ing the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

"(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term 'applicable imaging service' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

"(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

"(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

"(iii) one or more of such mechanisms is available free of charge.

"(D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (including an emergency

department), an ambulatory surgical center, and any other outpatient setting determined appropriate by the Secretary.

"(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term 'ordering professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service for an individual.

"(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term 'furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

"(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practi-

tioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other entities.

"(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

"(i) have stakeholder consensus;

"(ii) have been determined to be scientifically valid and are evidence based; and

"(iii) are in the public domain.

"(C) REVISIONS.—The Secretary shall periodically update and revise (as appropriate) such specification of applicable appropriate use criteria.

"(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary de-

termines that more than one appropriate use criteria applies with respect to an applicable imaging service, the Secretary shall specify one or more applicable appropriate use criteria under this paragraph for the service.

"(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(i) IN GENERAL.—The Secretary shall specify one or more qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

"(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, and other

stakeholders in specifying mechanisms under this paragraph.

"(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

"(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

"(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

"(III) Use of a clinical decision support mechanism established by the Secretary.

"(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

"(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

"(ii) REQUIREMENTS.—The requirements described in this clause are the following:

"(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

"(II) In the case where there are more than one applicable appropriate use criteria specified under such paragraph for an applicable

imaging service, the mechanism indicates the criteria that it uses for the service.

"(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

"(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

"(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

"(VI) The mechanism meets privacy and security

standards under applicable provisions of law.

"(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

"(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

"(ii) PERIODIC UPDATING OF LIST.—The Secretary shall periodically update the list of qualified clinical decision support mechanisms specified under this paragraph.

"(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

"(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

"(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

"(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), 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)), payment for

such service may only be made if the claim for the service includes the following:

"(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

"(ii) Information regarding—

"(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

"(II) whether the service ordered would not adhere to such criteria; or

"(III) whether such criteria was not applicable to the service ordered.

"(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

"(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

"(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

"(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

"(iii) ALTERNATIVE PAYMENT MODELS.—An applicable imaging service ordered by an ordering professional with respect to an individual attributed to an alternative payment model (as defined in section 1833(z)(3)(C)).

"(iv) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-

by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

"(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term 'applicable payment system' means the following:

"(i) The physician fee schedule established under section 1848(b).

"(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

"(iii) The ambulatory surgical center payment systems under section 1833(i).

"(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

"(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on a periodic basis (which may be annually), ordering professionals who are outlier ordering professionals.

"(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

"(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

"(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

"(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of

data to identify outlier ordering professionals under this paragraph.

"(D) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

"(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

"(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

"(B) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under

section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.".

(2) CONFORMING AMENDMENT.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

"(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(p).".

(b) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by subsection (a), is amended by adding at the end the following new subsection:

"(q) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary may establish an appropriate use program for services under this part (other than applicable imaging services under subsection (p)) using a process similar to the process under such subsection.

"(B) REQUIREMENTS.—In determining whether to establish a program under subparagraph (A), the Secretary shall take into consideration—

"(i) the implementation of appropriate use criteria for applicable imaging services under subsection (p); and

"(ii) the report under paragraph (2).

"(C) INPUT FROM STAKEHOLDERS IN ADVANCE OF RULEMAKING.—Before issuing a notice of proposed rulemaking to establish a program under

subparagraph (A), the Secretary shall issue an advance notice of proposed rulemaking.

"(2) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this subsection, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under this part, such as radiation therapy and clinical diagnostic laboratory services.".

SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.

(a) TRANSFERRING FREESTANDING PHYSICIAN COMPARE PROVISION TO THE SOCIAL SECURITY ACT.—

(1) IN GENERAL.—Section 10331 of Public Law 111–148 is transferred and redesignated as subsection (t) of section 1848 of the Social Security Act (42 U.S.C.

1395w–4), as amended by subsections (c) and (h) of section 2 and by section 3.

(2) CONFORMING REDESIGNATIONS.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as transferred and redesignated by paragraph (1), is further amended—

(A) by striking the subsection heading and inserting the following new subsection heading: "PUBLIC REPORTING OF PERFORMANCE AND OTHER INFORMATION ON PHYSICIAN COMPARE.—";

(B) by redesignating subsections (a) through (i) as paragraphs (1) through (9), respectively, and indenting appropriately;

(C) in paragraph (1), as redesignated by subparagraph (B)—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting appropriately;

(ii) in subparagraph (B), as redesignated by clause (i), by redes-

ignating subparagraphs (A) through (G) as clauses (i) through (vii), respectively, and indenting appropriately;

(D) in paragraph (2), as redesignated by subparagraph (B), by redesignating paragraphs (1) through (7) as subparagraphs (A) through (G), respectively, and indenting appropriately; and

(E) in paragraph (9), as redesignated by subparagraph (B), by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively, and indenting appropriately.

(3) CONFORMING AMENDMENTS.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as amended by paragraph (2), is further amended—

(A) in paragraph (1)—

(i) in subparagraph (A)—

(I) by striking "the Medicare program under section 1866(j) of the Social Security

Act (42 U.S.C. 1395cc(j))" and inserting "the program under this title under section 1866(j)"; and

(II) by striking "of such Act (42 U.S.C. 1395w–4)"; and

(ii) in subparagraph (B), in the matter preceding clause (i)—

(I) by striking "subsection (c)" and inserting "paragraph (3)";

(II) by striking "the Medicare program under such section 1866(j)" and inserting "the program under this title under section 1866(j)"; and

(III) by striking "this section" and inserting "this subsection";

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking "subsection (a)(2)" and inserting "paragraph (1)(B)";

(ii) in subparagraph (D), by striking "the Medicare program" and inserting "the program under this title"; and

(iii) in each of subparagraphs (F) and (G), by striking "this section" and inserting "this subsection";

(C) in paragraph (3), by striking "this section" and inserting "this subsection";

(D) in paragraph (4)—

(i) by striking "of the Social Security Act, as added by section 3014 of this Act"; and

(ii) by striking "this section" and inserting "this subsection";

(E) in paragraph (5)—

(i) by striking "this subsection (a)(2)" and inserting "paragraph (1)(B)"; and

(ii) by striking "(Public Law 110–275)";

(F) in paragraph (6), by striking "subsection (a)(1)" and inserting "paragraph (1)(A)";

(G) in paragraph (7)—

(i) by striking "subsection (f)" and inserting "paragraph (6)"; and

(ii) by striking "title XVIII of the Social Security Act" and inserting "this title";

(H) in paragraph (8)—

(i) by striking "subparagraphs (A) through (G) of subsection (a)(2)" and inserting "clauses (i) through (vii) of paragraph (1)(B)";

(ii) by striking "title XVIII of the Social Security Act" and inserting "this title"; and

(iii) by striking "such title" and inserting "this title"; and

(I) in paragraph (9)—

(i) in the matter preceding subparagraph (A), by striking "this section" and inserting "this subsection";

(ii) in subparagraph (A), by striking "of the Social Security Act (42 U.S.C. 1395w–4)";

(iii) in subparagraph (B), by striking "of such Act (42 U.S.C. 1395x(r))";

(iv) in subparagraph (C), by striking "subsection (a)(1)" and inserting "paragraph (1)(A)"; and

(v) by striking subparagraph (D).

(b) PUBLIC AVAILABILITY OF MEDICARE DATA.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as amended by subsection (a), is further amended—

(1) by redesignating paragraph (9) as paragraph (10);

(2) by inserting after paragraph (8) the following new paragraph:

"(9) PUBLIC AVAILABILITY OF ELIGIBLE PROFESSIONAL CLAIMS DATA.—

"(A) IN GENERAL.—The Secretary shall make publicly available on Physician Compare the information de-

scribed in subparagraph (B) with respect to eligible professionals.

"(B) INFORMATION DESCRIBED.—The following information, with respect to an eligible professional, is described in this subparagraph:

"(i) Information on the number of services furnished by the eligible professional, which may include information on the most frequent services furnished or groupings of services.

"(ii) Information on submitted charges and payments for services under this part.

"(iii) A unique identifier for the eligible professional that is available to the public, such as a national provider identifier.

"(C) SEARCHABILITY.—The information made available under this paragraph shall be searchable by at least the following:

"(i) The specialty or type of the eligible professional.

"(ii) Characteristics of the services furnished, such as volume or groupings of services.

"(iii) The location of the eligible professional.

"(D) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(E) IMPLEMENTATION.—

"(i) INITIAL IMPLEMENTATION.—Physician Compare shall include the information described in subparagraph (B)—

"(I) with respect to physicians, by not later than July 1, 2015; and

"(II) with respect to other eligible professionals, by not later than July 1, 2016.

"(ii) ANNUAL UPDATING.—The information made available under this paragraph shall be updated on Physician Compare not less frequently than on an annual basis.

"(F) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for an eligible professional to review, and submit corrections for, the information to be made public with respect to the eligible professional under this paragraph prior to such information being made public."; and

(3) in paragraph (10)(C), as redesignated by paragraph (1), by inserting "(or a successor website)" before the period at the end.

SEC. 8. EXPANDING CLAIMS DATA AVAILABILITY TO IMPROVE CARE.

(a) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended by adding at the end the following new paragraph:

"(5) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—

"(A) EXPANSION.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2014, notwithstanding paragraph (4)(B) (other than clause (iii) of such paragraph) and the second sentence of paragraph (4)(D), a qualified entity may, as determined appropriate by the Secretary, do any or all of the following:

"(i)(I) Use the combined data described in paragraph (4)(B)(iii) to conduct analyses, other than for reports described in paragraph (4), for entities described in subparagraph (B) for non-public uses, as determined appropriate

by the Secretary, such as for the purposes described in subclause (II).

"(II) The purposes described in this subclause are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities (including developing new models of care), population health management, and disease monitoring, and the purposes described in subparagraph (C).

"(ii) Provide or sell such analyses to entities described in subparagraph (B).

"(iii) Provide entities described in clauses (i), (ii), (v), and (vi) of subparagraph (B) with access to the combined data described in paragraph (4)(B)(iii) through a qualified data enclave (as defined in subparagraph (F)) that is maintained by the quali-

fied entity in order for entities described in such clauses to conduct analyses for non-public uses, such as for the purposes described in clause (i)(II).

"(B) ENTITIES DESCRIBED.—For the purpose of subparagraph (A) clauses (i) and (ii), the entities described in this subparagraph are the following:

"(i) A provider of services.

"(ii) A supplier.

"(iii) Subject to subparagraph (C), an employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

"(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act) that provides data under paragraph (4)(B)(iii).

"(v) A medical society or hospital association.

"(vi) Other entities approved by the Secretary (other than an

employer (as so defined) and a health insurance issuer (as so defined)).

"(C) LIMITATION WITH RESPECT TO EMPLOYERS.—Any analyses provided or sold under this paragraph to an employer (as so defined) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

"(D) PROTECTION OF PATIENT IDENTIFICATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), an analysis provided or sold under this paragraph shall not contain information that individually identifies a patient.

"(ii) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—An analysis that is provided or sold under this paragraph to a provider of services or supplier may contain data that individually identifies a patient of

such provider or supplier but only with respect to items and services furnished by such provider or supplier to such patient.

"(iii) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis under this paragraph to an entity described in subparagraph (B), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide an opportunity for such provider or supplier to review and submit corrections to such analysis.

"(E) NO REDISCLOSURE.—An entity described in subparagraph (B) that is provided or sold an analysis under this paragraph shall not redisclose or make public such an analysis.

"(F) REQUIREMENTS FOR A QUALIFIED DATA ENCLAVE.—

"(i) DEFINITION.—For purposes of this paragraph, the term 'qualified data enclave' means a data enclave that the Secretary determines meets the following:

"(I) The data enclave is a web-based portal or comparable mechanism.

"(II) Subject to the requirements described in clause (ii) and such other requirements as the Secretary may specify, the data enclave is capable of providing access to the combined data described in subparagraph (A)(iii).

"(ii) ENCLAVE ACCESS REQUIREMENTS.—The requirements described in this clause are the following:

"(I) A qualified data enclave shall preclude any enti-

ty that obtains access to the data from removing or extracting the data from such enclave.

"(II) Subject to the succeeding sentence, the enclave shall preclude access to data that individually identifies a patient, including data on the patient's name and date of birth and such other data as the Secretary shall specify. Such data enclave may provide providers of services and suppliers with access to such individually identifiable patient data but only with respect to items and services furnished by such provider or supplier to such patient.

"(III) Access to data in the enclave shall not be provided to any entity unless the qualified entity and the entity have entered into a data use agree-

ment, the terms of which contain the requirements of this paragraph and such other terms the Secretary may specify.

"(G) ANNUAL REPORTS.—Any qualified entity that provides or sells analyses pursuant to subparagraph (A)(ii) or provides access to a qualified data enclave pursuant to subparagraph (A)(iii) shall annually submit to the Secretary a report that includes—

"(i) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

"(ii) a description of the topics and purposes of such analyses;

"(iii) information on the entities who obtained access to the qualified data enclave, the uses of the data, and the total amount of

fees received for providing such access; and

"(iv) other information determined appropriate by the Secretary.".

(b) EXPANSION OF DATA AVAILABLE TO QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended—

(1) in the subsection heading, by striking "Medicare"; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: "Effective July 1, 2014, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity."; and

(B) in the last sentence, by inserting "or under titles XIX or XXI" before the period at the end.

(c) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)) is amended by adding at the end the following new clause:

"(vi) ACCESS TO MEDICARE DATA TO FACILITATE QUALITY IMPROVEMENT.—

"(I) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, and subject to other requirements as the Secretary may specify, beginning July 1, 2014, the Secretary shall, if requested by a qualified clinical data registry under this subparagraph, subject to subclauses (II) and (III), provide data as described in section

1874(e)(3) (in a form and manner determined to be appropriate) to such registry for purposes of linking such data with clinical data and performing analyses and research to support quality improvement or patient safety.

"(II) PROTECTION.—A qualified clinical data registry may not publicly report any data made available under subclause (I) (or any analyses or research described in such subclause) that individually identifies a provider of services, supplier, or individual unless the registry obtains the consent of such provider, supplier, or individual prior to such reporting.

"(III) FEE.—The data described in subclause (I) shall be made available to qualified clinical data registries at a fee

equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.".

(d) REVISION OF PLACEMENT OF FEES.—Section 1874(e)(4)(A) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(A)) is amended, in the second sentence—

(1) by inserting ", for periods prior to July 1, 2014," after "deposited"; and

(2) by inserting the following before the period at the end: ", and, beginning July 1, 2014, into the Centers for Medicare & Medicaid Services Program Management Account".

SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.

(a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-OUT TO PRIVATE CONTRACT.—

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

(A) IN GENERAL.—Section 1802(b)(3) of the Social Security Act (42 U.S.C. 1395a(b)(3)) is amended—

(i) in subparagraph (B)(ii), by striking "during the 2-year period beginning on the date the affidavit is signed" and inserting "during the applicable 2-year period (as defined in subparagraph (D))";

(ii) in subparagraph (C), by striking "during the 2-year period described in subparagraph (B)(ii)" and inserting "during the applicable 2-year period"; and

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

"(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each

subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.".

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act.

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a(b)) is amended—

(A) in paragraph (5), by adding at the end the following new subparagraph:

"(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).";

(B) by redesignating paragraph (5) as paragraph (6); and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

"(A) IN GENERAL.—Beginning not later than February 1, 2015, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

"(B) INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A)

shall include at least the following with respect to opt-out physicians and practitioners:

"(i) Their number.

"(ii) Their physician or professional specialty or other designation.

"(iii) Their geographic distribution.

"(iv) The timing of their becoming opt-out physicians and practitioners, relative to when they first entered practice and with respect to applicable 2-year periods.

"(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.".

(b) MEDICARE NON-PARTICIPATING PHYSICIANS DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish and implement a dem-

onstration project (in this section referred to as the "demonstration project") under title XVIII of the Social Security Act to provide that payments for services under such title furnished by non-participating physicians (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))) to individuals entitled to benefits under part A or enrolled under part B of such title are paid directly to such physicians. The Secretary shall carry out the demonstration project in a geographic area that is a statistically significant area no larger than a State.

(2) ADVANCE NOTICE TO PHYSICIANS.—The Secretary shall, in a timely manner and prior to the beginning of the year in which payment will be made under the demonstration project, notify physicians in the geographic area described in paragraph (1) of the option to participate in the demonstration project.

(3) TIMETABLE FOR IMPLEMENTATION.—

(A) DEMONSTRATION START DATE.—The demonstration project shall

apply with respect to services furnished beginning on January 1, 2015.

(B) 1-YEAR DURATION.—The Secretary shall implement the demonstration project such that payments are made under such demonstration project for a period of 1 year.

(4) REPORT.—Not later than 18 months after the date of the conclusion of the demonstration project, the Secretary shall submit to Congress a report analyzing the impact of the demonstration project. Such report shall include an analysis of the impact, if any, of the demonstration project upon the—

(A) percentage and number of physicians who choose not to participate under title XVIII of the Social Security Act and a comparison of such percentage and number to the previous year;

(B) percentage of claims submitted by and payments made to physicians in the demonstration that are

unassigned and a comparison of unassigned claims and payments by non-participating physicians in the previous year;

(C) percentage and number of the physicians in the demonstration by specialty designation; and

(D) access to services for which payment is made under such title for individuals entitled to benefits under part A or enrolled under part B of such title.

(5) BENEFICIARY NOTICE.—

(A) NOTICE BY SECRETARY TO BENEFICIARIES.—The Secretary shall notify individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act in the geographic area in which the demonstration project is conducted of the implications of physician participation in the demonstration project.

(B) NOTICE BY PHYSICIANS TO PATIENTS.—A physician who elects to participate in the demonstration

project shall notify individuals to whom the physician furnishes services for which payment will be provided under the demonstration project of such election. Such notification shall be provided prior to the provision of service and include a notification, with respect to each such individual, that—

(i) the right of the individual to payment is being reassigned to the physician;

(ii) payment for services furnished by the physician to such individual will be made directly to the physician; and

(iii) the individual is responsible for the remaining amount, which may be higher than would be the case if the physician participated in the Medicare program.

(c) GAINSHARING STUDY AND REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health

and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with legislative recommendations to amend existing fraud and abuse laws, through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships; and

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program

under title XVIII of the Social Security Act.

(d) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORD SYSTEMS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare EHR incentive programs, Congress declares it a national objective to achieve widespread and nationwide exchange of health information through interoperable certified EHR technology by December 31, 2019.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term "widespread interoperability" means nationwide interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare EHR in-

centive programs and other clinicians and health care providers.

(ii) INTEROPERABILITY.—The term "interoperability" means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than December 31, 2015, and in consultation with stakeholders, the Secretary shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services deter-

mines that the objective described in subparagraph (A) has not been achieved by December 31, 2017, then the Secretary shall submit to Congress a report, by not later than December 31, 2018, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before the period at the end

the following: ", and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation similar to that required in the health information technology donation safe harbor established under regulations under section 1128B(b)(3)(E)) that the professional has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology".

(B) FOR MEANINGFUL EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: ", and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation referred to in section 1848(o)(2)(A)(ii)) that the hospital has not and will not take any deliberate action to limit or restrict the use,

compatibility, or interoperability of the certified EHR technology".

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is 6 months after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A WEBSITE TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing a website (in this subsection referred to as the "website") that includes aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products. Such information may be made available through contracts with physician, hospital, or other or-

ganizations that maintain such comparative information.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the website. The report shall include information on the benefits and resources of such a website.

(4) DEFINITIONS.—In this subsection:

(A) The term "certified EHR technology" has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term "meaningful EHR hospital" means an eligible hospital (as defined in section 1886(n)(6)(A) of the Social Security Act (42 U.S.C. 1395ww(n)(6)(A)) that is a meaningful EHR user.

(C) The term "meaningful EHR professional" means an eligible professional (as defined in section 1848(o)(5)(C) of the Social Security

Act (42 U.S.C. 1395w–4(o)(5)(C)) who is a meaningful EHR user.

(D) The term "meaningful EHR user" has the meaning given such term under the Medicare EHR incentive programs.

(E) The term "Medicare EHR incentive programs" means the incentive programs under section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395w–4(o), 1395w–23, 1395ww(n)).

(F) The term "Secretary" means the Secretary of Health and Human Services.

(e) GAO STUDY AND REPORT ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and federal efforts can inform the use of telehealth in the Medicare

program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services conducts oversight of payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(f) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDER STANDARDS OF CARE.—

(1) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

(2) DEFINITIONS.—For purposes of this subsection:

(A) The term "Federal health care provision" means any provision of the Patient Protection and Affordable

Care Act (Public Law 111–148), title I and subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and titles XVIII and XIX of the Social Security Act.

(B) The term "health care provider" means any individual or entity—

(i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) The term "medical malpractice or medical liability action or claim" means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care

provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) The term "State" includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) NO PREEMPTION.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

Union Calendar No. 283

113TH CONGRESS
2D SESSION

H. R. 2810

[Report No. 113–257, Parts I and II]

A BILL

To amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians' services, and for other purposes.

MARCH 14, 2014

Reported from the Committee on Ways and Means with an amendment, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed