

113TH CONGRESS
2D SESSION

H. R. 4209

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 2014

Mr. TIERNEY introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, the Judiciary, and the Budget, 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

A BILL

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “SGR Repeal and Medicare Provider Payment Moderniza-
6 tion Act of 2014”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians' services.
- Sec. 3. Priorities and funding for measure development.
- Sec. 4. Encouraging care management for individuals with chronic care needs.
- Sec. 5. Ensuring accurate valuation of services under the physician fee schedule.
- Sec. 6. Promoting evidence-based care.
- Sec. 7. Empowering beneficiary choices through access to information on physicians' services.
- Sec. 8. Expanding availability of Medicare data.
- Sec. 9. Reducing administrative burden and other provisions.
- Sec. 10. Savings from overseas contingency and related activities.

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

6 (a) STABILIZING FEE UPDATES.—

7 (1) REPEAL OF SGR PAYMENT METHODOLOGY.—Section 1848 of the Social Security Act
 8 (42 U.S.C. 1395w–4) is amended—
 9

10 (A) in subsection (d)—

11 (i) in paragraph (1)(A), by inserting
 12 “or a subsequent paragraph” after “para-
 13 graph (4)”; and

14 (ii) in paragraph (4)—

15 (I) in the heading, by inserting
 16 “AND ENDING WITH 2013” after
 17 “YEARS BEGINNING WITH 2001”; and

1 (II) in subparagraph (A), by in-
 2 serting “and ending with 2013” after
 3 “a year beginning with 2001”; and

4 (B) in subsection (f)—

5 (i) in paragraph (1)(B), by inserting
 6 “through 2013” after “of each succeeding
 7 year”; and

8 (ii) in paragraph (2), in the matter
 9 preceding subparagraph (A), by inserting
 10 “and ending with 2013” after “beginning
 11 with 2000”.

12 (2) UPDATE OF RATES FOR APRIL THROUGH
 13 DECEMBER OF 2014, 2015, AND SUBSEQUENT
 14 YEARS.—Subsection (d) of section 1848 of the Social
 15 Security Act (42 U.S.C. 1395w–4) is amended by
 16 striking paragraph (15) and inserting the following
 17 new paragraphs:

18 “(15) UPDATE FOR 2014 THROUGH 2018.—The
 19 update to the single conversion factor established in
 20 paragraph (1)(C) for 2014 and each subsequent
 21 year through 2018 shall be 0.5 percent.

22 “(16) UPDATE FOR 2019 THROUGH 2023.—The
 23 update to the single conversion factor established in
 24 paragraph (1)(C) for 2019 and each subsequent
 25 year through 2023 shall be zero percent.

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

5 “(A) for items and services furnished by a
6 qualifying APM participant (as defined in sec-
7 tion 1833(z)(2)) for such year, 1.0 percent; and

8 “(B) for other items and services, 0.5 per-
9 cent.”.

10 (3) MEDPAC REPORTS.—

11 (A) INITIAL REPORT.—Not later than July
12 1, 2016, the Medicare Payment Advisory Com-
13 mission shall submit to Congress a report on
14 the relationship between—

15 (i) physician and other health profes-
16 sional utilization and expenditures (and the
17 rate of increase of such utilization and ex-
18 penditures) of items and services for which
19 payment is made under section 1848 of the
20 Social Security Act (42 U.S.C. 1395w–4);
21 and

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

1 Such report shall include a methodology to de-
2 scribe such relationship and the impact of
3 changes in such physician and other health pro-
4 fessional practice and service ordering patterns
5 on total utilization and expenditures under
6 parts A, B, and D of such title.

7 (B) FINAL REPORT.—Not later than July
8 1, 2020, the Medicare Payment Advisory Com-
9 mission shall submit to Congress a report on
10 the relationship described in subparagraph (A),
11 including the results determined from applying
12 the methodology included in the report sub-
13 mitted under such subparagraph.

14 (C) REPORT ON UPDATE TO PHYSICIANS'
15 SERVICES UNDER MEDICARE.—Not later than
16 July 1, 2018, the Medicare Payment Advisory
17 Commission shall submit to Congress a report
18 on—

19 (i) the payment update for profes-
20 sional services applied under the Medicare
21 program under title XVIII of the Social
22 Security Act for the period of years 2014
23 through 2018;

(ii) the effect of such update on the efficiency, economy, and quality of care provided under such program;

(iii) the effect of such update on ensuring a sufficient number of providers to maintain access to care by Medicare beneficiaries; and

(iv) recommendations for any future payment updates for professional services under such program to ensure adequate access to care is maintained for Medicare beneficiaries.

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PERFORMANCE PROGRAMS WITH NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(A) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section 1848(a)(7)(A) of the Social Security 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 2017”;

(ii) in clause (ii)—

1 (I) in the matter preceding sub-
 2 clause (I), by striking “Subject to
 3 clause (iii), for” and inserting “For”;

4 (II) in subclause (I), by adding
 5 at the end “and”;

6 (III) in subclause (II), by strik-
 7 ing “; and” and inserting a period;
 8 and

9 (IV) by striking subclause (III);
 10 and

11 (iii) by striking clause (iii).

12 (B) CONTINUATION OF MEANINGFUL USE
 13 DETERMINATIONS FOR MIPS.—Section
 14 1848(o)(2) of the Social Security Act (42
 15 U.S.C. 1395w-4(o)(2)) is amended—

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

18 (I) by striking “For purposes of
 19 paragraph (1), an” and inserting
 20 “An”; and

21 (II) by inserting “, or pursuant
 22 to subparagraph (D) for purposes of
 23 subsection (q), for a performance pe-
 24 riod under such subsection for a year”

1 after “under such subsection for a
2 year”; and

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

5 “(D) CONTINUED APPLICATION FOR PUR-
6 POSES OF MIPS.—With respect to 2018 and
7 each subsequent payment year, the Secretary
8 shall, for purposes of subsection (q) and in ac-
9 cordance with paragraph (1)(F) of such sub-
10 section, determine whether an eligible profes-
11 sional who is a MIPS eligible professional (as
12 defined in subsection (q)(1)(C)) for such year is
13 a meaningful EHR user under this paragraph
14 for the performance period under subsection (q)
15 for such year.”.

16 (2) QUALITY REPORTING.—

17 (A) SUNSETTING SEPARATE QUALITY RE-
18 PORTING INCENTIVES.—Section 1848(a)(8)(A)
19 of the Social Security Act (42 U.S.C. 1395w-
20 4(a)(8)(A)) is amended—

21 (i) in clause (i), by striking “or any
22 subsequent year” and inserting “or 2017”;
23 and

24 (ii) in clause (ii)(II), by striking “and
25 each subsequent year”.

1 (B) CONTINUATION OF QUALITY MEAS-
 2 URES AND PROCESSES FOR MIPS.—Section
 3 1848 of the Social Security Act (42 U.S.C.
 4 1395w–4) is amended—

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

7 “(9) CONTINUED APPLICATION FOR PURPOSES
 8 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-
 9 TEERING TO REPORT.—The Secretary shall, in ac-
 10 cordance with subsection (q)(1)(F), carry out the
 11 provisions of this subsection—

12 “(A) for purposes of subsection (q); and

13 “(B) for eligible professionals who are not
 14 MIPS eligible professionals (as defined in sub-
 15 section (q)(1)(C)) for the year involved.”; and

16 (ii) in subsection (m)—

17 (I) by redesignating paragraph
 18 (7) added by section 10327(a) of Pub-
 19 lic Law 111–148 as paragraph (8);
 20 and

21 (II) by adding at the end the fol-
 22 lowing new paragraph:

23 “(9) CONTINUED APPLICATION FOR PURPOSES
 24 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-
 25 TEERING TO REPORT.—The Secretary shall, in ac-

cordance with subsection (q)(1)(F), carry out the processes under this subsection—

“(A) for purposes of subsection (q); and

“(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.”.

(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, 2018, 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, 2018.”.

(B) CONTINUATION OF VALUE-BASED PAYMENT MODIFIER MEASURES FOR MIPS.—Section

1 1848(p) of the Social Security Act (42 U.S.C.
2 1395w-4(p)) is amended—

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

5 “(C) CONTINUED APPLICATION FOR PUR-
6 POSES OF MIPS.—The Secretary shall, in ac-
7 cordance with subsection (q)(1)(F), carry out
8 subparagraph (B) for purposes of subsection
9 (q).”; and

10 (ii) in paragraph (3), by adding at the
11 end the following: “With respect to 2018
12 and each subsequent year, the Secretary
13 shall, in accordance with subsection
14 (q)(1)(F), carry out this paragraph for
15 purposes of subsection (q).”.

16 (c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

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

20 “(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

21 “(1) ESTABLISHMENT.—

22 “(A) IN GENERAL.—Subject to the suc-
23 ceeding provisions of this subsection, the Sec-
24 retary shall establish an eligible professional
25 Merit-based Incentive Payment System (in this

subsection referred to as the ‘MIPS’) under which the Secretary shall—

“(i) develop a methodology for assessing the total performance of each MIPS 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 MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

“(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2018.

“(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

1 “(i) IN GENERAL.—For purposes of
2 this subsection, subject to clauses (ii) and
3 (iv), the term ‘MIPS eligible professional’
4 means—

5 “(I) for the first and second
6 years for which the MIPS applies to
7 payments (and for the performance
8 period for such first and second year),
9 a physician (as defined in section
10 1861(r)), a physician assistant, nurse
11 practitioner, and clinical nurse spe-
12 cialist (as such terms are defined in
13 section 1861(aa)(5)), and a certified
14 registered nurse anesthetist (as de-
15 fined in section 1861(bb)(2)) and a
16 group that includes such profes-
17 sionals; and

18 “(II) for the third year for which
19 the MIPS applies to payments (and
20 for the performance period for such
21 third year) and for each succeeding
22 year (and for the performance period
23 for each such year), the professionals
24 described in subclause (I) and such
25 other eligible professionals (as defined

1 in subsection (k)(3)(B)) as specified
2 by the Secretary and a group that in-
3 cludes such professionals.

4 “(ii) EXCLUSIONS.—For purposes of
5 clause (i), the term ‘MIPS eligible profes-
6 sional’ does not include, with respect to a
7 year, an eligible professional (as defined in
8 subsection (k)(3)(B)) who—

9 “(I) is a qualifying APM partici-
10 pant (as defined in section
11 1833(z)(2));

12 “(II) subject to clause (vii), is a
13 partial qualifying APM participant (as
14 defined in clause (iii)) for the most re-
15 cent period for which data are avail-
16 able and who, for the performance pe-
17 riod with respect to such year, does
18 not report on applicable measures and
19 activities described in paragraph
20 (2)(B) that are required to be re-
21 ported by such a professional under
22 the MIPS; or

23 “(III) for the performance period
24 with respect to such year, does not ex-

1 ceed the low-volume threshold meas-
2 urement selected under clause (iv).

3 “(iii) PARTIAL QUALIFYING APM PAR-
4 TICIPANT.—For purposes of this subpara-
5 graph, the term ‘partial qualifying APM
6 participant’ means, with respect to a year,
7 an eligible professional for whom the Sec-
8 retary determines the minimum payment
9 percentage (or percentages), as applicable,
10 described in paragraph (2) of section
11 1833(z) for such year have not been satis-
12 fied, but who would be considered a quali-
13 fying APM participant (as defined in such
14 paragraph) for such year if—

15 “(I) with respect to 2018 and
16 2019, the reference in subparagraph
17 (A) of such paragraph to 25 percent
18 was instead a reference to 20 percent;

19 “(II) with respect to 2020 and
20 2021—

21 “(aa) the reference in sub-
22 paragraph (B)(i) of such para-
23 graph to 50 percent was instead
24 a reference to 40 percent; and

1 “(bb) the references in sub-
2 paragraph (B)(ii) of such para-
3 graph to 50 percent and 25 per-
4 cent of such paragraph were in-
5 stead references to 40 percent
6 and 20 percent, respectively; and
7 “(III) with respect to 2022 and
8 subsequent years—

9 “(aa) the reference in sub-
10 paragraph (C)(i) of such para-
11 graph to 75 percent was instead
12 a reference to 50 percent; and

13 “(bb) the references in sub-
14 paragraph (C)(ii) of such para-
15 graph to 75 percent and 25 per-
16 cent of such paragraph were in-
17 stead references to 50 percent
18 and 20 percent, respectively.

19 “(iv) SELECTION OF LOW-VOLUME
20 THRESHOLD MEASUREMENT.—The Sec-
21 retary shall select a low-volume threshold
22 to apply for purposes of clause (ii)(III),
23 which may include one or more or a com-
24 bination of the following:

1 “(I) The minimum number (as
2 determined by the Secretary) of indi-
3 viduals enrolled under this part who
4 are treated by the eligible professional
5 for the performance period involved.

6 “(II) The minimum number (as
7 determined by the Secretary) of items
8 and services furnished to individuals
9 enrolled under this part by such pro-
10 fessional for such performance period.

11 “(III) The minimum amount (as
12 determined by the Secretary) of al-
13 lowed charges billed by such profes-
14 sional under this part for such per-
15 formance period.

16 “(v) TREATMENT OF NEW MEDICARE
17 ENROLLED ELIGIBLE PROFESSIONALS.—In
18 the case of a professional who first be-
19 comes a Medicare enrolled eligible profes-
20 sional during the performance period for a
21 year (and had not previously submitted
22 claims under this title such as a person, an
23 entity, or a part of a physician group or
24 under a different billing number or tax
25 identifier), such professional shall not be

1 treated under this subsection as a MIPS
2 eligible professional until the subsequent
3 year and performance period for such sub-
4 sequent year.

5 “(vi) CLARIFICATION.—In the case of
6 items and services furnished during a year
7 by an individual who is not a MIPS eligible
8 professional (including pursuant to clauses
9 (ii) and (v)) with respect to a year, in no
10 case shall a MIPS adjustment factor (or
11 additional MIPS adjustment factor) under
12 paragraph (6) apply to such individual for
13 such year.

14 “(vii) PARTIAL QUALIFYING APM PAR-
15 TICIPANT CLARIFICATIONS.—

16 “(I) TREATMENT AS MIPS ELIGI-
17 BLE PROFESSIONAL.—In the case of
18 an eligible professional who is a par-
19 tial qualifying APM participant, with
20 respect to a year, and who for the
21 performance period for such year re-
22 ports on applicable measures and ac-
23 tivities described in paragraph (2)(B)
24 that are required to be reported by
25 such a professional under the MIPS,

1 such eligible professional is considered
 2 to be a MIPS eligible professional
 3 with respect to such year.

4 “(II) NOT ELIGIBLE FOR QUALI-
 5 FYING APM PARTICIPANT PAY-
 6 MENTS.—In no case shall an eligible
 7 professional who is a partial quali-
 8 fying APM participant, with respect
 9 to a year, be considered a qualifying
 10 APM participant (as defined in para-
 11 graph (2) of section 1833(z)) for such
 12 year or be eligible for the additional
 13 payment under paragraph (1) of such
 14 section for such year.

15 “(D) APPLICATION TO GROUP PRAC-
 16 TICES.—

17 “(i) IN GENERAL.—Under the MIPS:

18 “(I) QUALITY PERFORMANCE
 19 CATEGORY.—The Secretary shall es-
 20 tablish and apply a process that in-
 21 cludes features of the provisions of
 22 subsection (m)(3)(C) for MIPS eligi-
 23 ble professionals in a group practice
 24 with respect to assessing performance
 25 of such group with respect to the per-

1 performance category described in clause
2 (i) of paragraph (2)(A).

3 “(II) OTHER PERFORMANCE CAT-
4 EGORIES.—The Secretary may estab-
5 lish and apply a process that includes
6 features of the provisions of sub-
7 section (m)(3)(C) for MIPS eligible
8 professionals in a group practice with
9 respect to assessing the performance
10 of such group with respect to the per-
11 formance categories described in
12 clauses (ii) through (iv) of such para-
13 graph.

14 “(ii) ENSURING COMPREHENSIVENESS
15 OF GROUP PRACTICE ASSESSMENT.—The
16 process established under clause (i) shall to
17 the extent practicable reflect the range of
18 items and services furnished by the MIPS
19 eligible professionals in the group practice
20 involved.

21 “(iii) CLARIFICATION.—MIPS eligible
22 professionals electing to be a virtual group
23 under paragraph (5)(I) shall not be consid-
24 ered MIPS eligible professionals in a group

1 practice for purposes of applying this sub-
2 paragraph.

3 “(E) USE OF REGISTRIES.—Under the
4 MIPS, the Secretary shall encourage the use of
5 qualified clinical data registries pursuant to
6 subsection (m)(3)(E) in carrying out this sub-
7 section.

8 “(F) APPLICATION OF CERTAIN PROVI-
9 SIONS.—In applying a provision of subsection
10 (k), (m), (o), or (p) for purposes of this sub-
11 section, the Secretary shall—

12 “(i) adjust the application of such
13 provision to ensure the provision is con-
14 sistent with the provisions of this sub-
15 section; and

16 “(ii) not apply such provision to the
17 extent that the provision is duplicative with
18 a provision of this subsection.

19 “(G) ACCOUNTING FOR RISK FACTORS.—

20 “(i) RISK FACTORS.—Taking into ac-
21 count the relevant studies conducted and
22 recommendations made in reports under
23 section 2(f)(1) of the SGR Repeal and
24 Medicare Provider Payment Modernization
25 Act of 2014, the Secretary, on an ongoing

1 basis, shall estimate how an individual's
2 health status and other risk factors affect
3 quality and resource use outcome measures
4 and, as feasible, shall incorporate informa-
5 tion from quality and resource use outcome
6 measurement (including care episode and
7 patient condition groups) into the MIPS.

8 “(ii) ACCOUNTING FOR OTHER FAC-
9 TORS IN PAYMENT ADJUSTMENTS.—Tak-
10 ing into account the studies conducted and
11 recommendations made in reports under
12 section 2(f)(1) of the SGR Repeal and
13 Medicare Provider Payment Modernization
14 Act of 2014 and other information as ap-
15 propriate, the Secretary shall account for
16 identified factors with an effect on quality
17 and resource use outcome measures when
18 determining payment adjustments, com-
19 posite performance scores, scores for per-
20 formance categories, or scores for meas-
21 ures or activities under the MIPS.

22 “(2) MEASURES AND ACTIVITIES UNDER PER-
23 FORMANCE CATEGORIES.—

24 “(A) PERFORMANCE CATEGORIES.—Under
25 the MIPS, 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 included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

1 “(ii) RESOURCE USE.—For the per-
2 formance category described in subpara-
3 graph (A)(ii), the measurement of resource
4 use for such period under subsection
5 (p)(3), using the methodology under sub-
6 section (r) as appropriate, and, as feasible
7 and applicable, accounting for the cost of
8 drugs under part D.

9 “(iii) CLINICAL PRACTICE IMPROVE-
10 MENT ACTIVITIES.—For the performance
11 category described in subparagraph
12 (A)(iii), clinical practice improvement ac-
13 tivities (as defined in subparagraph
14 (C)(v)(III)) under subcategories specified
15 by the Secretary for such period, which
16 shall include at least the following:

17 “(I) The subcategory of expanded
18 practice access, which shall include ac-
19 tivities such as same day appoint-
20 ments for urgent needs and after
21 hours access to clinician advice.

22 “(II) The subcategory of popu-
23 lation management, which shall in-
24 clude activities such as monitoring
25 health conditions of individuals to pro-

1 vide timely health care interventions
2 or participation in a qualified clinical
3 data registry.

4 “(III) The subcategory of care
5 coordination, which shall include ac-
6 tivities such as timely communication
7 of test results, timely exchange of
8 clinical information to patients and
9 other providers, and use of remote
10 monitoring or telehealth.

11 “(IV) The subcategory of bene-
12 ficiary engagement, which shall in-
13 clude activities such as the establish-
14 ment of care plans for individuals
15 with complex care needs, beneficiary
16 self-management assessment and
17 training, and using shared decision-
18 making mechanisms.

19 “(V) The subcategory of patient
20 safety and practice assessment, such
21 as through use of clinical or surgical
22 checklists and practice assessments
23 related to maintaining certification.

24 “(VI) The subcategory of partici-
25 pation in an alternative payment

1 model (as defined in section
2 1833(z)(3)(C)).

3 In establishing activities under this clause,
4 the Secretary shall give consideration to
5 the circumstances of small practices (con-
6 sisting of 15 or fewer professionals) and
7 practices located in rural areas and in
8 health professional shortage areas (as des-
9 ignated under section 332(a)(1)(A) of the
10 Public Health Service Act).

11 “(iv) MEANINGFUL EHR USE.—For
12 the performance category described in sub-
13 paragraph (A)(iv), the requirements estab-
14 lished for such period under subsection
15 (o)(2) for determining whether an eligible
16 professional is a meaningful EHR user.

17 “(C) ADDITIONAL PROVISIONS.—

18 “(i) EMPHASIZING OUTCOME MEAS-
19 URES UNDER THE QUALITY PERFORMANCE
20 CATEGORY.—In applying subparagraph
21 (B)(i), the Secretary shall, as feasible, em-
22 phasize the application of outcome meas-
23 ures.

24 “(ii) APPLICATION OF ADDITIONAL
25 SYSTEM MEASURES.—The Secretary may

1 use measures used for a payment system
2 other than for physicians, such as meas-
3 ures for inpatient hospitals, for purposes of
4 the performance categories described in
5 clauses (i) and (ii) of subparagraph (A).
6 For purposes of the previous sentence, the
7 Secretary may not use measures for hos-
8 pital outpatient departments, except in the
9 case of emergency physicians.

10 “(iii) GLOBAL AND POPULATION-
11 BASED MEASURES.—The Secretary may
12 use global measures, such as global out-
13 come measures, and population-based
14 measures for purposes of the performance
15 category described in subparagraph (A)(i).

16 “(iv) APPLICATION OF MEASURES AND
17 ACTIVITIES TO NON-PATIENT-FACING PRO-
18 FESSIONALS.—In carrying out this para-
19 graph, with respect to measures and activi-
20 ties specified in subparagraph (B) for per-
21 formance categories described in subpara-
22 graph (A), the Secretary—

23 “(I) shall give consideration to
24 the circumstances of professional
25 types (or subcategories of those types

determined by practice characteristics) who typically furnish 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 MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill 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.

“(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

“(I) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such

1 subparagraph and specifying criteria
2 for such activities.

3 “(II) CONTRACT AUTHORITY FOR
4 CLINICAL PRACTICE IMPROVEMENT
5 ACTIVITIES PERFORMANCE CAT-
6 EGORY.—In applying subparagraph
7 (B)(iii), the Secretary may contract
8 with entities to assist the Secretary
9 in—

10 “(aa) identifying activities
11 described in subparagraph
12 (B)(iii);

13 “(bb) specifying criteria for
14 such activities; and

15 “(cc) determining whether a
16 MIPS eligible professional meets
17 such criteria.

18 “(III) CLINICAL PRACTICE IM-
19 PROVEMENT ACTIVITIES DEFINED.—
20 For purposes of this subsection, the
21 term ‘clinical practice improvement
22 activity’ means an activity that rel-
23 evant eligible professional organiza-
24 tions and other relevant stakeholders
25 identify as improving clinical practice

1 or care delivery and that the Sec-
2 retary determines, when effectively ex-
3 ecuted, is likely to result in improved
4 outcomes.

5 “(D) ANNUAL LIST OF QUALITY MEASURES
6 AVAILABLE FOR MIPS ASSESSMENT.—

7 “(i) IN GENERAL.—Under the MIPS,
8 the Secretary, through notice and comment
9 rulemaking and subject to the succeeding
10 clauses of this subparagraph, shall, with
11 respect to the performance period for a
12 year, establish an annual final list of qual-
13 ity measures from which MIPS eligible
14 professionals may choose for purposes of
15 assessment under this subsection for such
16 performance period. Pursuant to the pre-
17 vious sentence, the Secretary shall—

18 “(I) not later than November 1
19 of the year prior to the first day of
20 the first performance period under the
21 MIPS, establish and publish in the
22 Federal Register a final list of quality
23 measures; and

24 “(II) not later than November 1
25 of the year prior to the first day of

1 each subsequent performance period,
2 update the final list of quality meas-
3 ures from the previous year (and pub-
4 lish such updated final list in the Fed-
5 eral Register), by—

6 “(aa) removing from such
7 list, as appropriate, quality meas-
8 ures, which may include the re-
9 moval of measures that are no
10 longer meaningful (such as meas-
11 ures that are topped out);

12 “(bb) adding to such list, as
13 appropriate, new quality meas-
14 ures; and

15 “(cc) determining whether
16 or not quality measures on such
17 list that have undergone sub-
18 stantive changes should be in-
19 cluded in the updated list.

20 “(ii) CALL FOR QUALITY MEAS-
21 URES.—

22 “(I) IN GENERAL.—Eligible pro-
23 fessional organizations and other rel-
24 evant stakeholders shall be requested
25 to identify and submit quality meas-

1 ures to be considered for selection
2 under this subparagraph in the an-
3 nual list of quality measures published
4 under clause (i) and to identify and
5 submit updates to the measures on
6 such list. For purposes of the previous
7 sentence, measures may be submitted
8 regardless of whether such measures
9 were previously published in a pro-
10 posed rule or endorsed by an entity
11 with a contract under section 1890(a).

12 “(II) ELIGIBLE PROFESSIONAL
13 ORGANIZATION DEFINED.—In this
14 subparagraph, the term ‘eligible pro-
15 fessional organization’ means a pro-
16 fessional organization as defined by
17 nationally recognized multispecialty
18 boards of certification or equivalent
19 certification boards.

20 “(iii) REQUIREMENTS.—In selecting
21 quality measures for inclusion in the an-
22 nual final list under clause (i), the Sec-
23 retary shall—

24 “(I) provide that, to the extent
25 practicable, all quality domains (as

1 defined in subsection (s)(1)(B)) are
2 addressed by such measures; and

3 “(II) ensure that such selection
4 is consistent with the process for se-
5 lection of measures under subsections
6 (k), (m), and (p)(2).

7 “(iv) PEER REVIEW.—Before includ-
8 ing a new measure or a measure described
9 in clause (i)(II)(cc) in the final list of
10 measures published under clause (i) for a
11 year, the Secretary shall submit for publi-
12 cation in applicable specialty-appropriate
13 peer-reviewed journals such measure and
14 the method for developing and selecting
15 such measure, including clinical and other
16 data supporting such measure.

17 “(v) MEASURES FOR INCLUSION.—
18 The final list of quality measures published
19 under clause (i) shall include, as applica-
20 ble, measures under subsections (k), (m),
21 and (p)(2), including quality measures
22 from among—

23 “(I) measures endorsed by a con-
24 sensus-based entity;

1 “(II) measures developed under
2 subsection (s); and

3 “(III) measures submitted under
4 clause (ii)(I).

5 Any measure selected for inclusion in such
6 list that is not endorsed by a consensus-
7 based entity shall have a focus that is evi-
8 dence-based.

9 “(vi) EXCEPTION FOR QUALIFIED
10 CLINICAL DATA REGISTRY MEASURES.—
11 Measures used by a qualified clinical data
12 registry under subsection (m)(3)(E) shall
13 not be subject to the requirements under
14 clauses (i), (iv), and (v). The Secretary
15 shall publish the list of measures used by
16 such qualified clinical data registries on
17 the Internet website of the Centers for
18 Medicare & Medicaid Services.

19 “(vii) EXCEPTION FOR EXISTING
20 QUALITY MEASURES.—Any quality meas-
21 ure specified by the Secretary under sub-
22 section (k) or (m), including under sub-
23 section (m)(3)(E), and any measure of
24 quality of care established under sub-
25 section (p)(2) for the reporting period

under the respective subsection beginning
before the first performance period under
the MIPS—

“(I) shall not be subject to the
requirements under clause (i) (except
under items (aa) and (cc) of subclause
(II) of such clause) or to the require-
ment under clause (iv); and

“(II) shall be included in the
final list of quality measures pub-
lished under clause (i) unless removed
under clause (i)(II)(aa).

“(viii) CONSULTATION WITH REL-
EVANT ELIGIBLE PROFESSIONAL ORGANI-
ZATIONS AND OTHER RELEVANT STAKE-
HOLDERS.—Relevant eligible professional
organizations and other relevant stake-
holders, including State and national med-
ical societies, shall be consulted in carrying
out this subparagraph.

“(ix) OPTIONAL APPLICATION.—The
process under section 1890A is not re-
quired to apply to the selection of meas-
ures under this subparagraph.

“(3) PERFORMANCE STANDARDS.—

1 “(A) ESTABLISHMENT.—Under the MIPS,
2 the Secretary shall establish performance stand-
3 ards with respect to measures and activities
4 specified under paragraph (2)(B) for a perform-
5 ance period (as established under paragraph
6 (4)) for a year.

7 “(B) CONSIDERATIONS IN ESTABLISHING
8 STANDARDS.—In establishing such performance
9 standards with respect to measures and activi-
10 ties specified under paragraph (2)(B), the Sec-
11 retary shall consider the following:

12 “(i) Historical performance standards.

13 “(ii) Improvement.

14 “(iii) The opportunity for continued
15 improvement.

16 “(4) PERFORMANCE PERIOD.—The Secretary
17 shall establish a performance period (or periods) for
18 a year (beginning with the year described in para-
19 graph (1)(B)). Such performance period (or periods)
20 shall begin and end prior to the beginning of such
21 year and be as close as possible to such year. In this
22 subsection, such performance period (or periods) for
23 a year shall be referred to as the performance period
24 for the year.

25 “(5) COMPOSITE PERFORMANCE SCORE.—

1 “(A) IN GENERAL.—Subject to the suc-
2 ceeding provisions of this paragraph and taking
3 into account, as available and applicable, para-
4 graph (1)(G), the Secretary shall develop a
5 methodology for assessing the total performance
6 of each MIPS eligible professional according to
7 performance standards under paragraph (3)
8 with respect to applicable measures and activi-
9 ties specified in paragraph (2)(B) with respect
10 to each performance category applicable to such
11 professional for a performance period (as estab-
12 lished under paragraph (4)) for a year. Using
13 such methodology, the Secretary shall provide
14 for a composite assessment (using a scoring
15 scale of 0 to 100) for each such professional for
16 the performance period for such year. In this
17 subsection such a composite assessment for
18 such a professional with respect to a perform-
19 ance period shall be referred to as the ‘com-
20 posite performance score’ for such professional
21 for such performance period.

22 “(B) INCENTIVE TO REPORT; ENCOUR-
23 AGING USE OF CERTIFIED EHR TECHNOLOGY
24 FOR REPORTING QUALITY MEASURES.—

1 “(i) INCENTIVE TO REPORT.—Under
2 the methodology established under sub-
3 paragraph (A), the Secretary shall provide
4 that in the case of a MIPS eligible profes-
5 sional who fails to report on an applicable
6 measure or activity that is required to be
7 reported by the professional, the profes-
8 sional shall be treated as achieving the
9 lowest potential score applicable to such
10 measure or activity.

11 “(ii) ENCOURAGING USE OF CER-
12 TIFIED EHR TECHNOLOGY AND QUALIFIED
13 CLINICAL DATA REGISTRIES FOR REPORT-
14 ING QUALITY MEASURES.—Under the
15 methodology established under subpara-
16 graph (A), the Secretary shall—

17 “(I) encourage MIPS eligible
18 professionals to report on applicable
19 measures with respect to the perform-
20 ance category described in paragraph
21 (2)(A)(i) through the use of certified
22 EHR technology and qualified clinical
23 data registries; and

24 “(II) with respect to a perform-
25 ance period, with respect to a year,

1 for which a MIPS eligible professional
2 reports such measures through the
3 use of such EHR technology, treat
4 such professional as satisfying the
5 clinical quality measures reporting re-
6 quirement described in subsection
7 (o)(2)(A)(iii) for such year.

8 “(C) CLINICAL PRACTICE IMPROVEMENT
9 ACTIVITIES PERFORMANCE SCORE.—

10 “(i) RULE FOR ACCREDITATION.—A
11 MIPS eligible professional who is in a
12 practice that is certified as a patient-cen-
13 tered medical home or comparable spe-
14 cialty practice pursuant to subsection
15 (b)(8)(B)(i) with respect to a performance
16 period shall be given the highest potential
17 score for the performance category de-
18 scribed in paragraph (2)(A)(iii) for such
19 period.

20 “(ii) APM PARTICIPATION.—Partici-
21 pation by a MIPS eligible professional in
22 an alternative payment model (as defined
23 in section 1833(z)(3)(C)) with respect to a
24 performance period shall earn such eligible
25 professional a minimum score of one-half

1 of the highest potential score for the per-
2 formance category described in paragraph
3 (2)(A)(iii) for such performance period.

4 “(iii) SUBCATEGORIES.—A MIPS eli-
5 gible professional shall not be required to
6 perform activities in each subcategory
7 under paragraph (2)(B)(iii) or participate
8 in an alternative payment model in order
9 to achieve the highest potential score for
10 the performance category described in
11 paragraph (2)(A)(iii).

12 “(D) ACHIEVEMENT AND IMPROVE-
13 MENT.—

14 “(i) TAKING INTO ACCOUNT IMPROVE-
15 MENT.—Beginning with the second year to
16 which the MIPS applies, in addition to the
17 achievement of a MIPS eligible profes-
18 sional, if data sufficient to measure im-
19 provement is available, the methodology
20 developed under subparagraph (A)—

21 “(I) in the case of the perform-
22 ance score for the performance cat-
23 egory described in clauses (i) and (ii)
24 of paragraph (2)(A), shall take into

1 account the improvement of the pro-
2 fessional; and

3 “(II) in the case of performance
4 scores for other performance cat-
5 egories, may take into account the im-
6 provement of the professional.

7 “(ii) ASSIGNING HIGHER WEIGHT FOR
8 ACHIEVEMENT.—Beginning with the
9 fourth year to which the MIPS applies,
10 under the methodology developed under
11 subparagraph (A), the Secretary may as-
12 sign a higher scoring weight under sub-
13 paragraph (F) with respect to the achieve-
14 ment of a MIPS eligible professional than
15 with respect to any improvement of such
16 professional applied under clause (i) with
17 respect to a measure, activity, or category
18 described in paragraph (2).

19 “(E) WEIGHTS FOR THE PERFORMANCE
20 CATEGORIES.—

21 “(i) IN GENERAL.—Under the meth-
22 odology developed under subparagraph (A),
23 subject to subparagraph (F)(i) and clauses
24 (ii) and (iii), the composite performance
25 score shall be determined as follows:

1 “(I) QUALITY.—

2 “(aa) IN GENERAL.—Sub-
3 ject to item (bb), thirty percent
4 of such score shall be based on
5 performance with respect to the
6 category described in clause (i) of
7 paragraph (2)(A). In applying
8 the previous sentence, the Sec-
9 retary shall, as feasible, encour-
10 age the application of outcome
11 measures within such category.

12 “(bb) FIRST 2 YEARS.—For
13 the first and second years for
14 which the MIPS applies to pay-
15 ments, the percentage applicable
16 under item (aa) shall be in-
17 creased in a manner such that
18 the total percentage points of the
19 increase under this item for the
20 respective year equals the total
21 number of percentage points by
22 which the percentage applied
23 under subclause (II)(bb) for the
24 respective year is less than 30
25 percent.

1 “(II) RESOURCE USE.—

2 “(aa) IN GENERAL.—Sub-
3 ject to item (bb), thirty percent
4 of such score shall be based on
5 performance with respect to the
6 category described in clause (ii)
7 of paragraph (2)(A).

8 “(bb) FIRST 2 YEARS.—For
9 the first year for which the MIPS
10 applies to payments, not more
11 than 10 percent of such score
12 shall be based on performance
13 with respect to the category de-
14 scribed in clause (ii) of para-
15 graph (2)(A). For the second
16 year for which the MIPS applies
17 to payments, not more than 15
18 percent of such score shall be
19 based on performance with re-
20 spect to the category described in
21 clause (ii) of paragraph (2)(A).

22 “(III) CLINICAL PRACTICE IM-
23 PROVEMENT ACTIVITIES.—Fifteen
24 percent of such score shall be based
25 on performance with respect to the

1 category described in clause (iii) of
2 paragraph (2)(A).

3 “(IV) MEANINGFUL USE OF CER-
4 TIFIED EHR TECHNOLOGY.—Twenty-
5 five percent of such score shall be
6 based on performance with respect to
7 the category described in clause (iv) of
8 paragraph (2)(A).

9 “(ii) AUTHORITY TO ADJUST PER-
10 CENTAGES IN CASE OF HIGH EHR MEAN-
11 INGFUL USE ADOPTION.—In any year in
12 which the Secretary estimates that the pro-
13 portion of eligible professionals (as defined
14 in subsection (o)(5)) who are meaningful
15 EHR users (as determined under sub-
16 section (o)(2)) is 75 percent or greater, the
17 Secretary may reduce the percent applica-
18 ble under clause (i)(IV), but not below 15
19 percent. If the Secretary makes such re-
20 duction for a year, subject to subclauses
21 (I)(bb) and (II)(bb) of clause (i), the per-
22 centages applicable under one or more of
23 subclauses (I), (II), and (III) of clause (i)
24 for such year shall be increased in a man-
25 ner such that the total percentage points

1 of the increase under this clause for such
2 year equals the total number of percentage
3 points reduced under the preceding sen-
4 tence for such year.

5 “(F) CERTAIN FLEXIBILITY FOR
6 WEIGHTING PERFORMANCE CATEGORIES, MEAS-
7 URES, AND ACTIVITIES.—Under the method-
8 ology under subparagraph (A), if there are not
9 sufficient measures and clinical practice im-
10 provement activities applicable and available to
11 each type of eligible professional involved, the
12 Secretary shall assign different scoring weights
13 (including a weight of 0)—

14 “(i) which may vary from the scoring
15 weights specified in subparagraph (E), for
16 each performance category based on the
17 extent to which the category is applicable
18 to the type of eligible professional involved;
19 and

20 “(ii) for each measure and activity
21 specified under paragraph (2)(B) with re-
22 spect to each such category based on the
23 extent to which the measure or activity is
24 applicable and available to the type of eli-
25 gible professional involved.

1 “(G) RESOURCE USE.—Analysis of the
2 performance category described in paragraph
3 (2)(A)(ii) shall include results from the method-
4 ology described in subsection (r)(5), as appro-
5 priate.

6 “(H) INCLUSION OF QUALITY MEASURE
7 DATA FROM OTHER PAYERS.—In applying sub-
8 sections (k), (m), and (p) with respect to meas-
9 ures described in paragraph (2)(B)(i), analysis
10 of the performance category described in para-
11 graph (2)(A)(i) may include data submitted by
12 MIPS eligible professionals with respect to
13 items and services furnished to individuals who
14 are not individuals entitled to benefits under
15 part A or enrolled under part B.

16 “(I) USE OF VOLUNTARY VIRTUAL GROUPS
17 FOR CERTAIN ASSESSMENT PURPOSES.—

18 “(i) IN GENERAL.—In the case of
19 MIPS eligible professionals electing to be a
20 virtual group under clause (ii) with respect
21 to a performance period for a year, for
22 purposes of applying the methodology
23 under subparagraph (A)—

24 “(I) the assessment of perform-
25 ance provided under such methodology

1 with respect to the performance cat-
2 egories described in clauses (i) and
3 (ii) of paragraph (2)(A) that is to be
4 applied to each such professional in
5 such group for such performance pe-
6 riod shall be with respect to the com-
7 bined performance of all such profes-
8 sionals in such group for such period;
9 and

10 “(II) the composite score pro-
11 vided under this paragraph for such
12 performance period with respect to
13 each such performance category for
14 each such MIPS eligible professional
15 in such virtual group shall be based
16 on the assessment of the combined
17 performance under subclause (I) for
18 the performance category and per-
19 formance period.

20 “(ii) ELECTION OF PRACTICES TO BE
21 A VIRTUAL GROUP.—The Secretary shall,
22 in accordance with clause (iii), establish
23 and have in place a process to allow an in-
24 dividual MIPS eligible professional or a
25 group practice consisting of not more than

1 10 MIPS eligible professionals to elect,
2 with respect to a performance period for a
3 year, for such individual MIPS eligible pro-
4 fessional or all such MIPS eligible profes-
5 sionals in such group practice, respectively,
6 to be a virtual group under this subpara-
7 graph with at least one other such indi-
8 vidual MIPS eligible professional or group
9 practice making such an election. Such a
10 virtual group may be based on geographic
11 areas or on provider specialties defined by
12 nationally recognized multispecialty boards
13 of certification or equivalent certification
14 boards and such other eligible professional
15 groupings in order to capture classifica-
16 tions of providers across eligible profes-
17 sional organizations and other practice
18 areas or categories.

19 “(iii) REQUIREMENTS.—The process
20 under clause (ii)—

21 “(I) shall provide that an election
22 under such clause, with respect to a
23 performance period, shall be made be-
24 fore or during the beginning of such
25 performance period and may not be

1 changed during such performance pe-
2 riod;

3 “(II) shall provide that a practice
4 described in such clause, and each
5 MIPS eligible professional in such
6 practice, may elect to be in no more
7 than one virtual group for a perform-
8 ance period; and

9 “(III) may provide that a virtual
10 group may be combined at the tax
11 identification number level.

12 “(6) MIPS PAYMENTS.—

13 “(A) MIPS ADJUSTMENT FACTOR.—Tak-
14 ing into account paragraph (1)(G), the Sec-
15 retary shall specify a MIPS adjustment factor
16 for each MIPS eligible professional for a year.
17 Such MIPS adjustment factor for a MIPS eligi-
18 ble professional for a year shall be in the form
19 of a percent and shall be determined—

20 “(i) by comparing the composite per-
21 formance score of the eligible professional
22 for such year to the performance threshold
23 established under subparagraph (D)(i) for
24 such year;

1 “(ii) in a manner such that the ad-
2 justment factors specified under this sub-
3 paragraph for a year result in differential
4 payments under this paragraph reflecting
5 that—

6 “(I) MIPS eligible professionals
7 with composite performance scores for
8 such year at or above such perform-
9 ance threshold for such year receive
10 zero or positive incentive payment ad-
11 justment factors for such year in ac-
12 cordance with clause (iii), with such
13 professionals having higher composite
14 performance scores receiving higher
15 adjustment factors; and

16 “(II) MIPS eligible professionals
17 with composite performance scores for
18 such year below such performance
19 threshold for such year receive nega-
20 tive payment adjustment factors for
21 such year in accordance with clause
22 (iv), with such professionals having
23 lower composite performance scores
24 receiving lower adjustment factors;

1 “(iii) in a manner such that MIPS eli-
2 gible professionals with composite scores
3 described in clause (ii)(I) for such year,
4 subject to clauses (i) and (ii) of subpara-
5 graph (F), receive a zero or positive ad-
6 justment factor on a linear sliding scale
7 such that an adjustment factor of 0 per-
8 cent is assigned for a score at the perform-
9 ance threshold and an adjustment factor of
10 the applicable percent specified in subpara-
11 graph (B) is assigned for a score of 100;
12 and

13 “(iv) in a manner such that—

14 “(I) subject to subclause (II),
15 MIPS eligible professionals with com-
16 posite performance scores described in
17 clause (ii)(II) for such year receive a
18 negative payment adjustment factor
19 on a linear sliding scale such that an
20 adjustment factor of 0 percent is as-
21 signed for a score at the performance
22 threshold and an adjustment factor of
23 the negative of the applicable percent
24 specified in subparagraph (B) is as-
25 signed for a score of 0; and

1 “(II) MIPS eligible professionals
 2 with composite performance scores
 3 that are equal to or greater than 0,
 4 but not greater than $\frac{1}{4}$ of the per-
 5 formance threshold specified under
 6 subparagraph (D)(i) for such year, re-
 7 ceive a negative payment adjustment
 8 factor that is equal to the negative of
 9 the applicable percent specified in
 10 subparagraph (B) for such year.

11 “(B) APPLICABLE PERCENT DEFINED.—
 12 For purposes of this paragraph, the term ‘ap-
 13 plicable percent’ means—

14 “(i) for 2018, 4 percent;
 15 “(ii) for 2019, 5 percent;
 16 “(iii) for 2020, 7 percent; and
 17 “(iv) for 2021 and subsequent years,
 18 9 percent.

19 “(C) ADDITIONAL MIPS ADJUSTMENT FAC-
 20 TORS FOR EXCEPTIONAL PERFORMANCE.—

21 “(i) IN GENERAL.—In the case of a
 22 MIPS eligible professional with a com-
 23 posite performance score for a year at or
 24 above the additional performance threshold
 25 under subparagraph (D)(ii) for such year,

1 in addition to the MIPS adjustment factor
 2 under subparagraph (A) for the eligible
 3 professional for such year, subject to the
 4 availability of funds under clause (ii), the
 5 Secretary shall specify an additional posi-
 6 tive MIPS adjustment factor for such pro-
 7 fessional and year. Such additional MIPS
 8 adjustment factors shall be determined by
 9 the Secretary in a manner such that pro-
 10 fessionals having higher composite per-
 11 formance scores above the additional per-
 12 formance threshold receive higher addi-
 13 tional MIPS adjustment factors.

14 “(ii) ADDITIONAL FUNDING POOL.—
 15 For 2018 and each subsequent year
 16 through 2023, there is appropriated from
 17 the Federal Supplementary Medical Insur-
 18 ance Trust Fund \$500,000,000 for MIPS
 19 payments under this paragraph resulting
 20 from the application of the additional
 21 MIPS adjustment factors under clause (i).

22 “(D) ESTABLISHMENT OF PERFORMANCE
 23 THRESHOLDS.—

24 “(i) PERFORMANCE THRESHOLD.—
 25 For each year of the MIPS, the Secretary

1 shall compute a performance threshold
2 with respect to which the composite per-
3 formance score of MIPS eligible profes-
4 sionals shall be compared for purposes of
5 determining adjustment factors under sub-
6 paragraph (A) that are positive, negative,
7 and zero. Such performance threshold for
8 a year shall be the mean or median (as se-
9 lected by the Secretary) of the composite
10 performance scores for all MIPS eligible
11 professionals with respect to a prior period
12 specified by the Secretary. The Secretary
13 may reassess the selection under the pre-
14 vious sentence every 3 years.

15 “(ii) ADDITIONAL PERFORMANCE
16 THRESHOLD FOR EXCEPTIONAL PERFORM-
17 ANCE.—In addition to the performance
18 threshold under clause (i), for each year of
19 the MIPS, the Secretary shall compute an
20 additional performance threshold for pur-
21 poses of determining the additional MIPS
22 adjustment factors under subparagraph
23 (C)(i). For each such year, the Secretary
24 shall apply either of the following methods

1 for computing such additional performance
2 threshold for such a year:

3 “(I) The threshold shall be the
4 score that is equal to the 25th per-
5 centile of the range of possible com-
6 posite performance scores above the
7 performance threshold with respect to
8 the prior period described in clause
9 (i).

10 “(II) The threshold shall be the
11 score that is equal to the 25th per-
12 centile of the actual composite per-
13 formance scores for MIPS eligible
14 professionals with composite perform-
15 ance scores at or above the perform-
16 ance threshold with respect to the
17 prior period described in clause (i).

18 “(iii) SPECIAL RULE FOR INITIAL 2
19 YEARS.—With respect to each of the first
20 two years to which the MIPS applies, the
21 Secretary shall, prior to the performance
22 period for such years, establish a perform-
23 ance threshold for purposes of determining
24 MIPS adjustment factors under subpara-
25 graph (A) and a threshold for purposes of

determining additional MIPS adjustment factors under subparagraph (C)(i). Each such performance threshold shall—

“(I) be based on a period prior to such performance periods; and

“(II) take into account—

“(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

“(bb) other factors determined appropriate by the Secretary.

“(E) APPLICATION OF MIPS ADJUSTMENT FACTORS.—In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2018), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

“(i) 1, plus

“(ii) the sum of—

1 “(I) the MIPS adjustment factor
2 determined under subparagraph (A)
3 divided by 100, and

4 “(II) as applicable, the additional
5 MIPS adjustment factor determined
6 under subparagraph (C)(i) divided by
7 100.

8 “(F) AGGREGATE APPLICATION OF MIPS
9 ADJUSTMENT FACTORS.—

10 “(i) APPLICATION OF SCALING FAC-
11 TOR.—

12 “(I) IN GENERAL.—With respect
13 to positive MIPS adjustment factors
14 under subparagraph (A)(ii)(I) for eli-
15 gible professionals whose composite
16 performance score is above the per-
17 formance threshold under subpara-
18 graph (D)(i) for such year, subject to
19 subclause (II), the Secretary shall in-
20 crease or decrease such adjustment
21 factors by a scaling factor in order to
22 ensure that the budget neutrality re-
23 quirement of clause (ii) is met.

1 “(II) SCALING FACTOR LIMIT.—

2 In no case may be the scaling factor
3 applied under this clause exceed 3.0.

4 “(ii) BUDGET NEUTRALITY REQUIRE-
5 MENT.—

6 “(I) IN GENERAL.—Subject to
7 clause (iii), the Secretary shall ensure
8 that the estimated amount described
9 in subclause (II) for a year is equal to
10 the estimated amount described in
11 subclause (III) for such year.

12 “(II) AGGREGATE INCREASES.—
13 The amount described in this sub-
14 clause is the estimated increase in the
15 aggregate allowed charges resulting
16 from the application of positive MIPS
17 adjustment factors under subpara-
18 graph (A) (after application of the
19 scaling factor described in clause (i))
20 to MIPS eligible professionals whose
21 composite performance score for a
22 year is above the performance thresh-
23 old under subparagraph (D)(i) for
24 such year.

1 “(III) AGGREGATE DE-
2 CREASES.—The amount described in
3 this subclause is the estimated de-
4 crease in the aggregate allowed
5 charges resulting from the application
6 of negative MIPS adjustment factors
7 under subparagraph (A) to MIPS eli-
8 gible professionals whose composite
9 performance score for a year is below
10 the performance threshold under sub-
11 paragraph (D)(i) for such year.

12 “(iii) EXCEPTIONS.—

13 “(I) In the case that all MIPS el-
14 igible professionals receive composite
15 performance scores for a year that are
16 below the performance threshold
17 under subparagraph (D)(i) for such
18 year, the negative MIPS adjustment
19 factors under subparagraph (A) shall
20 apply with respect to such MIPS eligi-
21 ble professionals and the budget neu-
22 trality requirement of clause (ii) shall
23 not apply for such year.

24 “(II) In the case that, with re-
25 spect to a year, the application of

1 clause (i) results in a scaling factor
2 equal to the maximum scaling factor
3 specified in clause (i)(II), such scaling
4 factor shall apply and the budget neu-
5 trality requirement of clause (ii) shall
6 not apply for such year.

7 “(iv) ADDITIONAL INCENTIVE PAY-
8 MENT ADJUSTMENTS.—In specifying the
9 MIPS additional adjustment factors under
10 subparagraph (C)(i) for each applicable
11 MIPS eligible professional for a year, the
12 Secretary shall ensure that the estimated
13 increase in payments under this part re-
14 sulting from the application of such addi-
15 tional adjustment factors for MIPS eligible
16 professionals in a year shall be equal (as
17 estimated by the Secretary) to the addi-
18 tional funding pool amount for such year
19 under subparagraph (C)(ii).

20 “(7) ANNOUNCEMENT OF RESULT OF ADJUST-
21 MENTS.—Under the MIPS, the Secretary shall, not
22 later than 30 days prior to January 1 of the year
23 involved, make available to MIPS eligible profes-
24 sionals the MIPS adjustment factor (and, as appli-
25 cable, the additional MIPS adjustment factor) under

1 paragraph (6) applicable to the eligible professional
2 for items and services furnished by the professional
3 for such year. The Secretary may include such infor-
4 mation in the confidential feedback under paragraph
5 (12).

6 “(8) NO EFFECT IN SUBSEQUENT YEARS.—The
7 MIPS adjustment factors and additional MIPS ad-
8 justment factors under paragraph (6) shall apply
9 only with respect to the year involved, and the Sec-
10 retary shall not take into account such adjustment
11 factors in making payments to a MIPS eligible pro-
12 fessional under this part in a subsequent year.

13 “(9) PUBLIC REPORTING.—

14 “(A) IN GENERAL.—The Secretary shall,
15 in an easily understandable format, make avail-
16 able on the Physician Compare Internet website
17 of the Centers for Medicare & Medicaid Serv-
18 ices the following:

19 “(i) Information regarding the per-
20 formance of MIPS eligible professionals
21 under the MIPS, which—

22 “(I) shall include the composite
23 score for each such MIPS eligible pro-
24 fessional and the performance of each
25 such MIPS eligible professional with

1 respect to each performance category;
2 and

3 “(II) may include the perform-
4 ance of each such MIPS eligible pro-
5 fessional with respect to each measure
6 or activity specified in paragraph
7 (2)(B).

8 “(ii) The names of eligible profes-
9 sionals in eligible alternative payment mod-
10 els (as defined in section 1833(z)(3)(D))
11 and, to the extent feasible, the names of
12 such eligible alternative payment models
13 and performance of such models.

14 “(B) DISCLOSURE.—The information
15 made available under this paragraph shall indi-
16 cate, where appropriate, that publicized infor-
17 mation may not be representative of the eligible
18 professional’s entire patient population, the va-
19 riety of services furnished by the eligible profes-
20 sional, or the health conditions of individuals
21 treated.

22 “(C) OPPORTUNITY TO REVIEW AND SUB-
23 MIT CORRECTIONS.—The Secretary shall pro-
24 vide for an opportunity for a professional de-
25 scribed in subparagraph (A) to review, and sub-

1 mit corrections for, the information to be made
2 public with respect to the professional under
3 such subparagraph prior to such information
4 being made public.

5 “(D) AGGREGATE INFORMATION.—The
6 Secretary shall periodically post on the Physi-
7 cian Compare Internet website aggregate infor-
8 mation on the MIPS, including the range of
9 composite scores for all MIPS eligible profes-
10 sionals and the range of the performance of all
11 MIPS eligible professionals with respect to each
12 performance category.

13 “(10) CONSULTATION.—The Secretary shall
14 consult with stakeholders in carrying out the MIPS,
15 including for the identification of measures and ac-
16 tivities under paragraph (2)(B) and the methodolo-
17 gies developed under paragraphs (5)(A) and (6) and
18 regarding the use of qualified clinical data registries.
19 Such consultation shall include the use of a request
20 for information or other mechanisms determined ap-
21 propriate.

22 “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-
23 TICES AND PRACTICES IN HEALTH PROFESSIONAL
24 SHORTAGE AREAS.—

1 “(A) IN GENERAL.—The Secretary shall
2 enter into contracts or agreements with appro-
3 priate entities (such as quality improvement or-
4 ganizations, regional extension centers (as de-
5 scribed in section 3012(c) of the Public Health
6 Service Act), or regional health collaboratives)
7 to offer guidance and assistance to MIPS eligi-
8 ble professionals in practices of 15 or fewer pro-
9 fessionals (with priority given to such practices
10 located in rural areas, health professional short-
11 age areas (as designated under in section
12 332(a)(1)(A) of such Act), and medically under-
13 served areas, and practices with low composite
14 scores) with respect to—

15 “(i) the performance categories de-
16 scribed in clauses (i) through (iv) of para-
17 graph (2)(A); or

18 “(ii) how to transition to the imple-
19 mentation of and participation in an alter-
20 native payment model as described in sec-
21 tion 1833(z)(3)(C).

22 “(B) FUNDING FOR IMPLEMENTATION.—

23 “(i) IN GENERAL.—For purposes of
24 implementing subparagraph (A), the Sec-
25 retary shall provide for the transfer from

1 the Federal Supplementary Medical Insur-
2 ance Trust Fund established under section
3 1841 to the Centers for Medicare & Med-
4 icaid Services Program Management Ac-
5 count of \$40,000,000 for each of fiscal
6 years 2015 through 2019. Amounts trans-
7 ferred under this subparagraph for a fiscal
8 year shall be available until expended.

9 “(ii) TECHNICAL ASSISTANCE.—Of
10 the amounts transferred pursuant to clause
11 (i) for each of fiscal years 2015 through
12 2019, not less than \$10,000,000 shall be
13 made available for each such year for tech-
14 nical assistance to small practices in health
15 professional shortage areas (as so des-
16 ignated) and medically underserved areas.

17 “(12) FEEDBACK AND INFORMATION TO IM-
18 PROVE PERFORMANCE.—

19 “(A) PERFORMANCE FEEDBACK.—

20 “(i) IN GENERAL.—Beginning July 1,
21 2016, the Secretary—

22 “(I) shall make available timely
23 (such as quarterly) confidential feed-
24 back to MIPS eligible professionals on
25 the performance of such professionals

1 with respect to the performance cat-
2 egories under clauses (i) and (ii) of
3 paragraph (2)(A); and

4 “(II) may make available con-
5 fidential feedback to each such profes-
6 sional on the performance of such
7 professional with respect to the per-
8 formance categories under clauses (iii)
9 and (iv) of such paragraph.

10 “(ii) MECHANISMS.—The Secretary
11 may use one or more mechanisms to make
12 feedback available under clause (i), which
13 may include use of a web-based portal or
14 other mechanisms determined appropriate
15 by the Secretary. With respect to the per-
16 formance category described in paragraph
17 (2)(A)(i), feedback under this subpara-
18 graph shall, to the extent an eligible pro-
19 fessional chooses to participate in a data
20 registry for purposes of this subsection (in-
21 cluding registries under subsections (k)
22 and (m)), be provided based on perform-
23 ance on quality measures reported through
24 the use of such registries. With respect to
25 any other performance category described

1 in paragraph (2)(A), the Secretary shall
2 encourage provision of feedback through
3 qualified clinical data registries as de-
4 scribed in subsection (m)(3)(E).

5 “(iii) USE OF DATA.—For purposes of
6 clause (i), the Secretary may use data,
7 with respect to a MIPS eligible profes-
8 sional, from periods prior to the current
9 performance period and may use rolling
10 periods in order to make illustrative cal-
11 culations about the performance of such
12 professional.

13 “(iv) DISCLOSURE EXEMPTION.—
14 Feedback made available under this sub-
15 paragraph shall be exempt from disclosure
16 under section 552 of title 5, United States
17 Code.

18 “(v) RECEIPT OF INFORMATION.—
19 The Secretary may use the mechanisms es-
20 tablished under clause (ii) to receive infor-
21 mation from professionals, such as infor-
22 mation with respect to this subsection.

23 “(B) ADDITIONAL INFORMATION.—

24 “(i) IN GENERAL.—Beginning July 1,
25 2017, the Secretary shall make available to

1 each MIPS eligible professional informa-
2 tion, with respect to individuals who are
3 patients of such MIPS eligible professional,
4 about items and services for which pay-
5 ment is made under this title that are fur-
6 nished to such individuals by other sup-
7 pliers and providers of services, which may
8 include information described in clause (ii).
9 Such information may be made available
10 under the previous sentence to such MIPS
11 eligible professionals by mechanisms deter-
12 mined appropriate by the Secretary, which
13 may include use of a web-based portal.
14 Such information may be made available in
15 accordance with the same or similar terms
16 as data are made available to accountable
17 care organizations participating in the
18 shared savings program under section
19 1899, including a beneficiary opt-out.

20 “(ii) TYPE OF INFORMATION.—For
21 purposes of clause (i), the information de-
22 scribed in this clause, is the following:

23 “(I) With respect to selected
24 items and services (as determined ap-
25 propriate by the Secretary) for which

1 payment is made under this title and
2 that are furnished to individuals, who
3 are patients of a MIPS eligible profes-
4 sional, by another supplier or provider
5 of services during the most recent pe-
6 riod for which data are available (such
7 as the most recent three-month pe-
8 riod), such as the name of such pro-
9 viders furnishing such items and serv-
10 ices to such patients during such pe-
11 riod, the types of such items and serv-
12 ices so furnished, and the dates such
13 items and services were so furnished.

14 “(II) Historical data, such as
15 averages and other measures of the
16 distribution if appropriate, of the
17 total, and components of, allowed
18 charges (and other figures as deter-
19 mined appropriate by the Secretary).

20 “(13) REVIEW.—

21 “(A) TARGETED REVIEW.—The Secretary
22 shall establish a process under which a MIPS
23 eligible professional may seek an informal re-
24 view of the calculation of the MIPS adjustment
25 factor applicable to such eligible professional

1 under this subsection for a year. The results of
2 a review conducted pursuant to the previous
3 sentence shall not be taken into account for
4 purposes of paragraph (6) with respect to a
5 year (other than with respect to the calculation
6 of such eligible professional's MIPS adjustment
7 factor for such year or additional MIPS adjust-
8 ment factor for such year) after the factors de-
9 termined in subparagraph (A) and subpara-
10 graph (C) of such paragraph have been deter-
11 mined for such year.

12 “(B) LIMITATION.—Except as provided for
13 in subparagraph (A), there shall be no adminis-
14 trative or judicial review under section 1869,
15 section 1878, or otherwise of the following:

16 “(i) The methodology used to deter-
17 mine the amount of the MIPS adjustment
18 factor under paragraph (6)(A) and the
19 amount of the additional MIPS adjustment
20 factor under paragraph (6)(C)(i) and the
21 determination of such amounts.

22 “(ii) The establishment of the per-
23 formance standards under paragraph (3)
24 and the performance period under para-
25 graph (4).

“(iii) 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 (9).

“(iv) 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 MIPS.—Not later than October 1, 2019, and October 1, 2022, the Comptroller General of the United States shall submit to Congress a report evaluating the eligible professional Merit-based Incentive Payment System 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 composite performance scores and MIPS adjustment factors (and additional MIPS

1 adjustment factors) for MIPS eligible pro-
2 fessionals (as defined in subsection
3 (q)(1)(c) of such section) under such pro-
4 gram, and patterns relating to such scores
5 and adjustment factors, including based on
6 type of provider, practice size, geographic
7 location, and patient mix;

8 (ii) provide recommendations for im-
9 proving such program;

10 (iii) evaluate the impact of technical
11 assistance funding under section
12 1848(q)(11) of the Social Security Act, as
13 added by paragraph (1), on the ability of
14 professionals to improve within such pro-
15 gram or successfully transition to an alter-
16 native payment model (as defined in sec-
17 tion 1833(z)(3) of the Social Security Act,
18 as added by subsection (e)), with priority
19 for such evaluation given to practices lo-
20 cated in rural areas, health professional
21 shortage areas (as designated in section
22 332(a)(1)(a) of the Public Health Service
23 Act), and medically underserved areas; and

1 (iv) provide recommendations for opti-
2 mizing the use of such technical assistance
3 funds.

4 (B) STUDY TO EXAMINE ALIGNMENT OF
5 QUALITY MEASURES USED IN PUBLIC AND PRI-
6 VATE PROGRAMS.—

7 (i) IN GENERAL.—Not later than 18
8 months after the date of the enactment of
9 this Act, the Comptroller General of the
10 United States shall submit to Congress a
11 report that—

12 (I) compares the similarities and
13 differences in the use of quality meas-
14 ures under the original Medicare fee-
15 for-service program under parts A and
16 B of title XVIII of the Social Security
17 Act, the Medicare Advantage program
18 under part C of such title, selected
19 State Medicaid programs under title
20 XIX of such Act, and private payer
21 arrangements; and

22 (II) makes recommendations on
23 how to reduce the administrative bur-
24 den involved in applying such quality
25 measures.

1 (ii) REQUIREMENTS.—The report
2 under clause (i) shall—

3 (I) consider those measures ap-
4 plicable to individuals entitled to, or
5 enrolled for, benefits under such part
6 A, or enrolled under such part B and
7 individuals under the age of 65; and

8 (II) focus on those measures that
9 comprise the most significant compo-
10 nent of the quality performance cat-
11 egory of the eligible professional
12 MIPS incentive program under sub-
13 section (q) of section 1848 of the So-
14 cial Security Act (42 U.S.C. 1395w-
15 4), as added by paragraph (1).

16 (C) STUDY ON ROLE OF INDEPENDENT
17 RISK MANAGERS.—Not later than January 1,
18 2016, the Comptroller General of the United
19 States shall submit to Congress a report exam-
20 ining whether entities that pool financial risk
21 for physician practices, such as independent
22 risk managers, can play a role in supporting
23 physician practices, particularly small physician
24 practices, in assuming financial risk for the
25 treatment of patients. Such report shall exam-

1 ine barriers that small physician practices cur-
2 rently face in assuming financial risk for treat-
3 ing patients, the types of risk management enti-
4 ties that could assist physician practices in par-
5 ticipating in two-sided risk payment models,
6 and how such entities could assist with risk
7 management and with quality improvement ac-
8 tivities. Such report shall also include an anal-
9 ysis of any existing legal barriers to such ar-
10 rangements.

11 (D) STUDY TO EXAMINE RURAL AND
12 HEALTH PROFESSIONAL SHORTAGE AREA AL-
13 TERNATIVE PAYMENT MODELS.—Not later than
14 October 1, 2020, and October 1, 2022, the
15 Comptroller General of the United States shall
16 submit to Congress a report that examines the
17 transition of professionals in rural areas, health
18 professional shortage areas (as designated in
19 section 332(a)(1)(A) of the Public Health Serv-
20 ice Act), or medically underserved areas to an
21 alternative payment model (as defined in sec-
22 tion 1833(z)(3) of the Social Security Act, as
23 added by subsection (e)). Such report shall
24 make recommendations for removing adminis-
25 trative barriers to practices, including small

practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas to participation in such models.

(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 \$80,000,000 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 2018. 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 2015 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 2014”; and

(B) by inserting “and, for reporting periods occurring in 2015 and subsequent years, the Secretary may establish” following “shall establish”.

(3) PHYSICIAN FEEDBACK PROGRAM REPORTS SUCCEEDED BY REPORTS UNDER MIPS.—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:

1 “(11) REPORTS ENDING WITH 2016.—Reports
2 under the Program shall not be provided after De-
3 cember 31, 2016. See subsection (q)(12) for reports
4 under the eligible professionals Merit-based Incentive
5 Payment System.”.

6 (4) COORDINATION WITH SATISFYING MEANING-
7 FUL EHR USE CLINICAL QUALITY MEASURE REPORT-
8 ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of
9 the Social Security Act (42 U.S.C. 1395w-
10 4(o)(2)(A)(iii)) is amended by inserting “and sub-
11 section (q)(5)(B)(ii)(II)” after “Subject to subpara-
12 graph (B)(ii)”.

13 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

14 (1) INCREASING TRANSPARENCY OF PHYSICIAN
15 FOCUSED PAYMENT MODELS.—Section 1868 of the
16 Social Security Act (42 U.S.C. 1395ee) is amended
17 by adding at the end the following new subsection:

18 “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

19 “(1) TECHNICAL ADVISORY COMMITTEE.—

20 “(A) ESTABLISHMENT.—There is estab-
21 lished an ad hoc committee to be known as the
22 ‘Payment Model Technical Advisory Committee’
23 (referred to in this subsection as the ‘Com-
24 mittee’).

25 “(B) MEMBERSHIP.—

1 “(i) NUMBER AND APPOINTMENT.—

2 The Committee shall be composed of 11
3 members appointed by the Comptroller
4 General of the United States.

5 “(ii) QUALIFICATIONS.—The member-

6 ship of the Committee shall include indi-
7 viduals with national recognition for their
8 expertise in payment models and related
9 delivery of care. No more than 5 members
10 of the Committee shall be providers of
11 services or suppliers, or representatives of
12 providers of services or suppliers.

13 “(iii) PROHIBITION ON FEDERAL EM-

14 PLOYMENT.—A member of the Committee
15 shall not be an employee of the Federal
16 Government.

17 “(iv) ETHICS DISCLOSURE.—The

18 Comptroller General shall establish a sys-
19 tem for public disclosure by members of
20 the Committee of financial and other po-
21 tential conflicts of interest relating to such
22 members. Members of the Committee shall
23 be treated as employees of Congress for
24 purposes of applying title I of the Ethics

1 in Government Act of 1978 (Public Law
2 95–521).

3 “(v) DATE OF INITIAL APPOINT-
4 MENTS.—The initial appointments of mem-
5 bers of the Committee shall be made by
6 not later than 180 days after the date of
7 enactment of this subsection.

8 “(C) TERM; VACANCIES.—

9 “(i) TERM.—The terms of members of
10 the Committee shall be for 3 years except
11 that the Comptroller General shall des-
12 ignate staggered terms for the members
13 first appointed.

14 “(ii) VACANCIES.—Any member ap-
15 pointed to fill a vacancy occurring before
16 the expiration of the term for which the
17 member’s predecessor was appointed shall
18 be appointed only for the remainder of that
19 term. A member may serve after the expi-
20 ration of that member’s term until a suc-
21 cesssor has taken office. A vacancy in the
22 Committee shall be filled in the manner in
23 which the original appointment was made.

24 “(D) DUTIES.—The Committee shall meet,
25 as needed, to provide comments and rec-

ommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

“(E) COMPENSATION OF MEMBERS.—

“(i) IN GENERAL.—Except as provided in clause (ii), a member of the Committee shall serve without compensation.

“(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

“(F) OPERATIONAL AND TECHNICAL SUPPORT.—

“(i) IN GENERAL.—The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Med-

1 icaid Services shall provide to the Com-
2 mittee actuarial assistance as needed.

3 “(ii) FUNDING.—The Secretary shall
4 provide for the transfer, from the Federal
5 Supplementary Medical Insurance Trust
6 Fund under section 1841, such amounts as
7 are necessary to carry out clause (i) (not
8 to exceed \$5,000,000) for fiscal year 2014
9 and each subsequent fiscal year. Any
10 amounts transferred under the preceding
11 sentence for a fiscal year shall remain
12 available until expended.

13 “(G) APPLICATION.—Section 14 of the
14 Federal Advisory Committee Act (5 U.S.C.
15 App.) shall not apply to the Committee.

16 “(2) CRITERIA AND PROCESS FOR SUBMISSION
17 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT
18 MODELS.—

19 “(A) CRITERIA FOR ASSESSING PHYSICIAN-
20 FOCUSED PAYMENT MODELS.—

21 “(i) RULEMAKING.—Not later than
22 November 1, 2015, the Secretary shall,
23 through notice and comment rulemaking,
24 following a request for information, estab-
25 lish criteria for physician-focused payment

1 models, including models for specialist phy-
2 sicians, that could be used by the Com-
3 mittee for making comments and rec-
4 ommendations pursuant to paragraph
5 (1)(D).

6 “(ii) MEDPAC SUBMISSION OF COM-
7 MENTS.—During the comment period for
8 the proposed rule described in clause (i),
9 the Medicare Payment Advisory Commis-
10 sion may submit comments to the Sec-
11 retary on the proposed criteria under such
12 clause.

13 “(iii) UPDATING.—The Secretary may
14 update the criteria established under this
15 subparagraph through rulemaking.

16 “(B) STAKEHOLDER SUBMISSION OF PHY-
17 SICIAN FOCUSED PAYMENT MODELS.—On an
18 ongoing basis, individuals and stakeholder enti-
19 ties may submit to the Committee proposals for
20 physician-focused payment models that such in-
21 dividuals and entities believe meet the criteria
22 described in subparagraph (A).

23 “(C) TAC REVIEW OF MODELS SUB-
24 MITTED.—The Committee shall, on a periodic
25 basis, review models submitted under subpara-

graph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

“(D) SECRETARY REVIEW AND RESPONSE.—The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet website of the Centers for Medicare & Medicaid Services.

“(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.”.

(2) 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.—

1 “(A) IN GENERAL.—In the case of covered
2 professional services furnished by an eligible
3 professional during a year that is in the period
4 beginning with 2018 and ending with 2023 and
5 for which the professional is a qualifying APM
6 participant, in addition to the amount of pay-
7 ment that would otherwise be made for such
8 covered professional services under this part for
9 such year, there also shall be paid to such pro-
10 fessional an amount equal to 5 percent of the
11 payment amount for the covered professional
12 services under this part for the preceding year.
13 For purposes of the previous sentence, the pay-
14 ment amount for the preceding year may be an
15 estimation for the full preceding year based on
16 a period of such preceding year that is less than
17 the full year. The Secretary shall establish poli-
18 cies to implement this subparagraph in cases
19 where payment for covered professional services
20 furnished by a qualifying APM participant in
21 an alternative payment model is made to an en-
22 tity participating in the alternative payment
23 model rather than directly to the qualifying
24 APM participant.

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

4 “(C) TREATMENT OF PAYMENT INCEN-
5 TIVE.—Payments under this subsection shall
6 not be taken into account for purposes of deter-
7 mining actual expenditures under an alternative
8 payment model and for purposes of determining
9 or rebasing any benchmarks used under the al-
10 ternative payment model.

11 “(D) COORDINATION.—The amount of the
12 additional payment for an item or service under
13 this subsection or subsection (m) shall be deter-
14 mined without regard to any additional pay-
15 ment for the item or service under subsection
16 (m) and this subsection, respectively. The
17 amount of the additional payment for an item
18 or service under this subsection or subsection
19 (x) shall be determined without regard to any
20 additional payment for the item or service
21 under subsection (x) and this subsection, re-
22 spectively. The amount of the additional pay-
23 ment for an item or service under this sub-
24 section or subsection (y) shall be determined
25 without regard to any additional payment for

1 the item or service under subsection (y) and
2 this subsection, respectively.

3 “(2) QUALIFYING APM PARTICIPANT.—For pur-
4 poses of this subsection, the term ‘qualifying APM
5 participant’ means the following:

6 “(A) 2018 AND 2019.—With respect to
7 2018 and 2019, an eligible professional for
8 whom the Secretary determines that at least 25
9 percent of payments under this part for covered
10 professional services furnished by such profes-
11 sional during the most recent period for which
12 data are available (which may be less than a
13 year) were attributable to such services fur-
14 nished under this part through an entity that
15 participates in an eligible alternative payment
16 model with respect to such services.

17 “(B) 2020 AND 2021.—With respect to
18 2020 and 2021, an eligible professional de-
19 scribed in either of the following clauses:

20 “(i) MEDICARE REVENUE THRESHOLD
21 OPTION.—An eligible professional for
22 whom the Secretary determines that at
23 least 50 percent of payments under this
24 part for covered professional services fur-
25 nished by such professional during the

1 most recent period for which data are
2 available (which may be less than a year)
3 were attributable to such services furnished
4 under this part through an entity that par-
5 ticipates in an eligible alternative payment
6 model with respect to such services.

7 “(ii) COMBINATION ALL-PAYER AND
8 MEDICARE REVENUE THRESHOLD OP-
9 TION.—An eligible professional—

10 “(I) for whom the Secretary de-
11 termines, with respect to items and
12 services furnished by such professional
13 during the most recent period for
14 which data are available (which may
15 be less than a year), that at least 50
16 percent of the sum of—

17 “(aa) payments described in
18 clause (i); and

19 “(bb) all other payments, re-
20 gardless of payer (other than
21 payments made by the Secretary
22 of Defense or the Secretary of
23 Veterans Affairs under chapter
24 55 of title 10, United States
25 Code, or title 38, United States

1 Code, or any other provision of
2 law, and other than payments
3 made under title XIX in a State
4 in which no medical home or al-
5 ternative payment model is avail-
6 able under the State program
7 under that title),
8 meet the requirement described in
9 clause (iii)(I) with respect to pay-
10 ments described in item (aa) and meet
11 the requirement described in clause
12 (iii)(II) with respect to payments de-
13 scribed in item (bb);
14 “(II) for whom the Secretary de-
15 termines at least 25 percent of pay-
16 ments under this part for covered pro-
17 fessional services furnished by such
18 professional during the most recent
19 period for which data are available
20 (which may be less than a year) were
21 attributable to such services furnished
22 under this part through an entity that
23 participates in an eligible alternative
24 payment model with respect to such
25 services; and

1 “(III) who provides to the Sec-
2 retary such information as is nec-
3 essary for the Secretary to make a de-
4 termination under subclause (I), with
5 respect to such professional.

6 “(iii) REQUIREMENT.—For purposes
7 of clause (ii)(I)—

8 “(I) the requirement described in
9 this subclause, with respect to pay-
10 ments described in item (aa) of such
11 clause, is that such payments are
12 made under an eligible alternative
13 payment model; and

14 “(II) the requirement described
15 in this subclause, with respect to pay-
16 ments described in item (bb) of such
17 clause, is that such payments are
18 made under an arrangement in
19 which—

20 “(aa) quality measures com-
21 parable to measures under the
22 performance category described
23 in section 1848(q)(2)(B)(i) apply;

24 “(bb) certified EHR tech-
25 nology is used; and

1 “(cc) the eligible profes-
2 sional (AA) bears more than
3 nominal financial risk if actual
4 aggregate expenditures exceeds
5 expected aggregate expenditures;
6 or (BB) is a medical home (with
7 respect to beneficiaries under
8 title XIX) that meets criteria
9 comparable to medical homes ex-
10 panded under section 1115A(c).

11 “(C) BEGINNING IN 2022.—With respect to
12 2022 and each subsequent year, an eligible pro-
13 fessional described in either of the following
14 clauses:

15 “(i) MEDICARE REVENUE THRESHOLD
16 OPTION.—An eligible professional for
17 whom the Secretary determines that at
18 least 75 percent of payments under this
19 part for covered professional services fur-
20 nished by such professional during the
21 most recent period for which data are
22 available (which may be less than a year)
23 were attributable to such services furnished
24 under this part through an entity that par-

1 participates in an eligible alternative payment
2 model with respect to such services.

3 “(ii) COMBINATION ALL-PAYER AND
4 MEDICARE REVENUE THRESHOLD OP-
5 TION.—An eligible professional—

6 “(I) for whom the Secretary de-
7 termines, with respect to items and
8 services furnished by such professional
9 during the most recent period for
10 which data are available (which may
11 be less than a year), that at least 75
12 percent of the sum of—

13 “(aa) payments described in
14 clause (i); and

15 “(bb) all other payments, re-
16 gardless of payer (other than
17 payments made by the Secretary
18 of Defense or the Secretary of
19 Veterans Affairs under chapter
20 55 of title 10, United States
21 Code, or title 38, United States
22 Code, or any other provision of
23 law, and other than payments
24 made under title XIX in a State
25 in which no medical home or al-

1 ternative payment model is avail-
2 able under the State program
3 under that title),
4 meet the requirement described in
5 clause (iii)(I) with respect to pay-
6 ments described in item (aa) and meet
7 the requirement described in clause
8 (iii)(II) with respect to payments de-
9 scribed in item (bb);

10 “(II) for whom the Secretary de-
11 termines at least 25 percent of pay-
12 ments under this part for covered pro-
13 fessional services furnished by such
14 professional during the most recent
15 period for which data are available
16 (which may be less than a year) were
17 attributable to such services furnished
18 under this part through an entity that
19 participates in an eligible alternative
20 payment model with respect to such
21 services; and

22 “(III) who provides to the Sec-
23 retary such information as is nec-
24 essary for the Secretary to make a de-

1 termination under subclause (I), with
2 respect to such professional.

3 “(iii) REQUIREMENT.—For purposes
4 of clause (ii)(I)—

5 “(I) the requirement described in
6 this subclause, with respect to pay-
7 ments described in item (aa) of such
8 clause, is that such payments are
9 made under an eligible alternative
10 payment model; and

11 “(II) the requirement described
12 in this subclause, with respect to pay-
13 ments described in item (bb) of such
14 clause, is that such payments are
15 made under an arrangement in
16 which—

17 “(aa) quality measures com-
18 parable to measures under the
19 performance category described
20 in section 1848(q)(2)(B)(i) apply;

21 “(bb) certified EHR tech-
22 nology is used; and

23 “(cc) the eligible profes-
24 sional (AA) bears more than
25 nominal financial risk if actual

1 aggregate expenditures exceeds
2 expected aggregate expenditures;
3 or (BB) is a medical home (with
4 respect to beneficiaries under
5 title XIX) that meets criteria
6 comparable to medical homes ex-
7 panded under section 1115A(c).

8 “(3) ADDITIONAL DEFINITIONS.—In this sub-
9 section:

10 “(A) COVERED PROFESSIONAL SERV-
11 ICES.—The term ‘covered professional services’
12 has the meaning given that term in section
13 1848(k)(3)(A).

14 “(B) ELIGIBLE PROFESSIONAL.—The term
15 ‘eligible professional’ has the meaning given
16 that term in section 1848(k)(3)(B).

17 “(C) ALTERNATIVE PAYMENT MODEL
18 (APM).—The term ‘alternative payment model’
19 means any of the following:

20 “(i) A model under section 1115A
21 (other than a health care innovation
22 award).

23 “(ii) The shared savings program
24 under section 1899.

1 “(iii) A demonstration under section
2 1866C.

3 “(iv) A demonstration required by
4 Federal law.

5 “(D) ELIGIBLE ALTERNATIVE PAYMENT
6 MODEL (APM).—

7 “(i) IN GENERAL.—The term ‘eligible
8 alternative payment model’ means, with re-
9 spect to a year, an alternative payment
10 model—

11 “(I) that requires use of certified
12 EHR technology (as defined in sub-
13 section (o)(4));

14 “(II) that provides for payment
15 for covered professional services based
16 on quality measures comparable to
17 measures under the performance cat-
18 egory described in section
19 1848(q)(2)(B)(i); and

20 “(III) that satisfies the require-
21 ment described in clause (ii).

22 “(ii) ADDITIONAL REQUIREMENT.—
23 For purposes of clause (i)(III), the require-
24 ment described in this clause, with respect
25 to a year and an alternative payment

1 model, is that the alternative payment
2 model—

3 “(I) is one in which one or more
4 entities bear financial risk for mone-
5 tary losses under such model that are
6 in excess of a nominal amount; or

7 “(II) is a medical home expanded
8 under section 1115A(c).

9 “(4) LIMITATION.—There shall be no adminis-
10 trative or judicial review under section 1869, 1878,
11 or otherwise, of the following:

12 “(A) The determination that an eligible
13 professional is a qualifying APM participant
14 under paragraph (2) and the determination
15 that an alternative payment model is an eligible
16 alternative payment model under paragraph
17 (3)(D).

18 “(B) The determination of the amount of
19 the 5 percent payment incentive under para-
20 graph (1)(A), including any estimation as part
21 of such determination.”.

22 (3) COORDINATION CONFORMING AMEND-
23 MENTS.—Section 1833 of the Social Security Act
24 (42 U.S.C. 1395l) is further amended—

1 (A) in subsection (x)(3), by adding at the
 2 end the following new sentence: “The amount
 3 of the additional payment for a service under
 4 this subsection and subsection (z) shall be de-
 5 termined without regard to any additional pay-
 6 ment for the service under subsection (z) and
 7 this subsection, respectively.”; and

8 (B) in subsection (y)(3), by adding at the
 9 end the following new sentence: “The amount
 10 of the additional payment for a service under
 11 this subsection and subsection (z) shall be de-
 12 termined without regard to any additional pay-
 13 ment for the service under subsection (z) and
 14 this subsection, respectively.”.

15 (4) ENCOURAGING DEVELOPMENT AND TEST-
 16 ING OF CERTAIN MODELS.—Section 1115A(b)(2) of
 17 the Social Security Act (42 U.S.C. 1315a(b)(2)) is
 18 amended—

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

21 “(xxi) Focusing primarily on physi-
 22 cians’ services (as defined in section
 23 1848(j)(3)) furnished by physicians who
 24 are not primary care practitioners.

1 “(xxii) Focusing on practices of 15 or
2 fewer professionals.

3 “(xxiii) Focusing on risk-based models
4 for small physician practices which may in-
5 volve two-sided risk and prospective patient
6 assignment, and which examine risk-ad-
7 justed decreases in mortality rates, hos-
8 pital readmissions rates, and other relevant
9 and appropriate clinical measures.

10 “(xxiv) Focusing primarily on title
11 XIX, working in conjunction with the Cen-
12 ter for Medicaid and CHIP Services.”; and
13 (B) in subparagraph (C)(viii), by striking
14 “other public sector or private sector payers”
15 and inserting “other public sector payers, pri-
16 vate sector payers, or Statewide payment mod-
17 els”.

18 (5) CONSTRUCTION REGARDING TELEHEALTH
19 SERVICES.—Nothing in the provisions of, or amend-
20 ments made by, this Act shall be construed as pre-
21 cluding an alternative payment model or a qualifying
22 APM participant (as those terms are defined in sec-
23 tion 1833(z) of the Social Security Act, as added by
24 paragraph (1)) from furnishing a telehealth service
25 for which payment is not made under section

1 1834(m) of the Social Security Act (42 U.S.C.
2 1395m(m)).

3 (6) INTEGRATING MEDICARE ADVANTAGE AL-
4 TERNATIVE PAYMENT MODELS.—Not later than July
5 1, 2015, the Secretary of Health and Human Serv-
6 ices shall submit to Congress a study that examines
7 the feasibility of integrating alternative payment
8 models in the Medicare Advantage payment system.
9 The study shall include the feasibility of including a
10 value-based modifier and whether such modifier
11 should be budget neutral.

12 (7) STUDY AND REPORT ON FRAUD RELATED
13 TO ALTERNATIVE PAYMENT MODELS UNDER THE
14 MEDICARE PROGRAM.—

15 (A) STUDY.—The Secretary of Health and
16 Human Services, in consultation with the In-
17 spector General of the Department of Health
18 and Human Services, shall conduct a study
19 that—

20 (i) examines the applicability of the
21 Federal fraud prevention laws to items and
22 services furnished under title XVIII of the
23 Social Security Act for which payment is
24 made under an alternative payment model

1 (as defined in section 1833(z)(3)(C) of
2 such Act (42 U.S.C. 1395l(z)(3)(C)));

3 (ii) identifies aspects of such alter-
4 native payment models that are vulnerable
5 to fraudulent activity; and

6 (iii) examines the implications of waiv-
7 ers to such laws granted in support of such
8 alternative payment models, including
9 under any potential expansion of such
10 models.

11 (B) REPORT.—Not later than 2 years after
12 the date of the enactment of this Act, the Sec-
13 retary shall submit to Congress a report con-
14 taining the results of the study conducted under
15 subparagraph (A). Such report shall include
16 recommendations for actions to be taken to re-
17 duce the vulnerability of such alternative pay-
18 ment models to fraudulent activity. Such report
19 also shall include, as appropriate, recommenda-
20 tions of the Inspector General for changes in
21 Federal fraud prevention laws to reduce such
22 vulnerability.

23 (f) IMPROVING PAYMENT ACCURACY.—

1 (1) STUDIES AND REPORTS OF EFFECT OF CER-
2 TAIN INFORMATION ON QUALITY AND RESOURCE
3 USE.—

4 (A) STUDY USING EXISTING MEDICARE
5 DATA.—

6 (i) STUDY.—The Secretary of Health
7 and Human Services (in this subsection re-
8 ferred to as the “Secretary”) shall conduct
9 a study that examines the effect of individ-
10 uals’ socioeconomic status on quality and
11 resource use outcome measures for individ-
12 uals under the Medicare program (such as
13 to recognize that less healthy individuals
14 may require more intensive interventions).
15 The study shall use information collected
16 on such individuals in carrying out such
17 program, such as urban and rural location,
18 eligibility for Medicaid (recognizing and ac-
19 counting for varying Medicaid eligibility
20 across States), and eligibility for benefits
21 under the supplemental security income
22 (SSI) program. The Secretary shall carry
23 out this paragraph acting through the As-
24 sistant Secretary for Planning and Evalua-
25 tion.

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

6 (B) STUDY USING OTHER DATA.—

7 (i) STUDY.—The Secretary shall con-
8 duct a study that examines the impact of
9 risk factors, such as those described in sec-
10 tion 1848(p)(3) of the Social Security Act
11 (42 U.S.C. 1395w-4(p)(3)), race, health
12 literacy, limited English proficiency (LEP),
13 and patient activation, on quality and re-
14 source use outcome measures under the
15 Medicare program (such as to recognize
16 that less healthy individuals may require
17 more intensive interventions). In con-
18 ducting such study the Secretary may use
19 existing Federal data and collect such ad-
20 ditional data as may be necessary to com-
21 plete the study.

22 (ii) REPORT.—Not later than 5 years
23 after the date of the enactment of this Act,
24 the Secretary shall submit to Congress a

1 report on the study conducted under clause
2 (i).

3 (C) EXAMINATION OF DATA IN CON-
4 DUCTING STUDIES.—In conducting the studies
5 under subparagraphs (A) and (B), the Sec-
6 retary shall examine what non-Medicare data
7 sets, such as data from the American Commu-
8 nity Survey (ACS), can be useful in conducting
9 the types of studies under such paragraphs and
10 how such data sets that are identified as useful
11 can be coordinated with Medicare administra-
12 tive data in order to improve the overall data
13 set available to do such studies and for the ad-
14 ministration of the Medicare program.

15 (D) RECOMMENDATIONS TO ACCOUNT FOR
16 INFORMATION IN PAYMENT ADJUSTMENT
17 MECHANISMS.—If the studies conducted under
18 subparagraphs (A) and (B) find a relationship
19 between the factors examined in the studies and
20 quality and resource use outcome measures,
21 then the Secretary shall also provide rec-
22 ommendations for how the Centers for Medicare
23 & Medicaid Services should—

24 (i) obtain access to the necessary data
25 (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 Merit-based Incentive Payment System 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 Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act to the Secretary to carry out this paragraph \$6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) HIERARCHICAL 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, as the Secretary determines appropriate, estimate how

1 an individual's health status and other risk fac-
2 tors affect quality and resource use outcome
3 measures and, as feasible, shall incorporate in-
4 formation from quality and resource use out-
5 come measurement (including care episode and
6 patient condition groups) into provisions of title
7 XVIII of the Social Security Act that are simi-
8 lar to the eligible professional Merit-based In-
9 centive Payment System under section 1848(q)
10 of such Act.

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

13 (i) IN GENERAL.—Taking into ac-
14 count the studies conducted and rec-
15 ommendations made in reports under para-
16 graph (1) and other information as appro-
17 priate, the Secretary shall, as the Sec-
18 retary determines appropriate, account for
19 identified factors with an effect on quality
20 and resource use outcome measures when
21 determining payment adjustment mecha-
22 nisms under provisions of title XVIII of
23 the Social Security Act that are similar to
24 the eligible professional Merit-based Incen-

1 tive Payment System under section
2 1848(q) of such Act.

3 (ii) ACCESSING DATA.—The Secretary
4 shall collect or otherwise obtain access to
5 the data necessary to carry out this para-
6 graph through existing and new data
7 sources.

8 (iii) PERIODIC ANALYSES.—The Sec-
9 retary shall carry out periodic analyses, at
10 least every 3 years, based on the factors
11 referred to in clause (i) so as to monitor
12 changes in possible relationships.

13 (C) FUNDING.—There are hereby appro-
14 priated from the Federal Supplementary Med-
15 ical Insurance Trust Fund under section 1841
16 of the Social Security Act to the Secretary to
17 carry out this paragraph and the application of
18 this paragraph to the Merit-based Incentive
19 Payment System under section 1848(q) of such
20 Act \$10,000,000, to remain available until ex-
21 pended.

22 (3) STRATEGIC PLAN FOR ACCESSING RACE
23 AND ETHNICITY DATA.—Not later than 18 months
24 after the date of the enactment of this Act, the Sec-
25 retary shall develop and report to Congress on a

1 strategic plan for collecting or otherwise accessing
2 data on race and ethnicity for purposes of carrying
3 out the eligible professional Merit-based Incentive
4 Payment System under section 1848(q) of the Social
5 Security Act and, as the Secretary determines ap-
6 propriate, other similar provisions of title XVIII of
7 such Act.

8 (g) COLLABORATING WITH THE PHYSICIAN, PRACTI-
9 TIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
10 IMPROVE RESOURCE USE MEASUREMENT.—Section 1848
11 of the Social Security Act (42 U.S.C. 1395w–4), as
12 amended by subsection (c), is further amended by adding
13 at the end the following new subsection:

14 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-
15 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
16 IMPROVE RESOURCE USE MEASUREMENT.—

17 “(1) IN GENERAL.—In order to involve the phy-
18 sician, practitioner, and other stakeholder commu-
19 nities in enhancing the infrastructure for resource
20 use measurement, including for purposes of the
21 value-based performance incentive program under
22 subsection (q) and alternative payment models under
23 section 1833(z), the Secretary shall undertake the
24 steps described in the succeeding provisions of this
25 subsection.

1 “(2) DEVELOPMENT OF CARE EPISODE AND PA-
2 TIENT CONDITION GROUPS AND CLASSIFICATION
3 CODES.—

4 “(A) IN GENERAL.—In order to classify
5 similar patients into care episode groups and
6 patient condition groups, the Secretary shall
7 undertake the steps described in the succeeding
8 provisions of this paragraph.

9 “(B) PUBLIC AVAILABILITY OF EXISTING
10 EFFORTS TO DESIGN AN EPISODE GROUPER.—
11 Not later than 120 days after the date of the
12 enactment of this subsection, the Secretary
13 shall post on the Internet website of the Cen-
14 ters for Medicare & Medicaid Services a list of
15 the episode groups developed pursuant to sub-
16 section (n)(9)(A) and related descriptive infor-
17 mation.

18 “(C) STAKEHOLDER INPUT.—The Sec-
19 retary shall accept, through the date that is 60
20 days after the day the Secretary posts the list
21 pursuant to subparagraph (B), suggestions
22 from physician specialty societies, applicable
23 practitioner organizations, and other stake-
24 holders for episode groups in addition to those
25 posted pursuant to such subparagraph, and

specific clinical criteria and patient characteristics to classify patients into—

“(i) care episode groups; and

“(ii) 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 care episode groups and patient condition groups, which account for a target of an estimated $\frac{2}{3}$ 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

1 care, such as the clinical conditions or
2 diagnoses, whether or not inpatient
3 hospitalization is anticipated or oc-
4 curs, and the principal procedures or
5 services planned or furnished; and

6 “(II) other factors determined
7 appropriate by the Secretary.

8 “(iii) PATIENT CONDITION GROUPS.—
9 In establishing the patient condition
10 groups under clause (i), the Secretary shall
11 take into account—

12 “(I) the patient’s clinical history
13 at the time of each medical visit, such
14 as the patient’s combination of chron-
15 ic conditions, current health status,
16 and recent significant history (such as
17 hospitalization and major surgery dur-
18 ing a previous period, such as 3
19 months); and

20 “(II) other factors determined
21 appropriate by the Secretary, such as
22 eligibility status under this title (in-
23 cluding eligibility under section
24 226(a), 226(b), or 226A, and dual eli-
25 gibility under this title and title XIX).

1 “(E) DRAFT CARE EPISODE AND PATIENT
2 CONDITION GROUPS AND CLASSIFICATION
3 CODES.—Not later than 180 days after the end
4 of the comment period described in subpara-
5 graph (C), the Secretary shall post on the
6 Internet website of the Centers for Medicare &
7 Medicaid Services a draft list of the care epi-
8 sode and patient condition codes established
9 under subparagraph (D) (and the criteria and
10 characteristics assigned to such code).

11 “(F) SOLICITATION OF INPUT.—The Sec-
12 retary shall seek, through the date that is 60
13 days after the Secretary posts the list pursuant
14 to subparagraph (E), comments from physician
15 specialty societies, applicable practitioner orga-
16 nizations, and other stakeholders, including rep-
17 resentatives of individuals entitled to benefits
18 under part A or enrolled under this part, re-
19 garding the care episode and patient condition
20 groups (and codes) posted under subparagraph
21 (E). In seeking such comments, the Secretary
22 shall use one or more mechanisms (other than
23 notice and comment rulemaking) that may in-
24 clude use of open door forums, town hall meet-
25 ings, or other appropriate mechanisms.

1 “(G) OPERATIONAL LIST OF CARE EPI-
2 SODE AND PATIENT CONDITION GROUPS AND
3 CODES.—Not later than 180 days after the end
4 of the comment period described in subpara-
5 graph (F), taking into account the comments
6 received under such subparagraph, the Sec-
7 retary shall post on the Internet website of the
8 Centers for Medicare & Medicaid Services an
9 operational list of care episode and patient con-
10 dition codes (and the criteria and characteris-
11 tics assigned to such code).

12 “(H) SUBSEQUENT REVISIONS.—Not later
13 than November 1 of each year (beginning with
14 2017), the Secretary shall, through rulemaking,
15 make revisions to the operational lists of care
16 episode and patient condition codes as the Sec-
17 retary determines may be appropriate. Such re-
18 visions may be based on experience, new infor-
19 mation developed pursuant to subsection
20 (n)(9)(A), and input from the physician spe-
21 cialty societies, applicable practitioner organiza-
22 tions, and other stakeholders, including rep-
23 resentatives of individuals entitled to benefits
24 under part A or enrolled under this part.

1 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-
2 CIANS OR PRACTITIONERS.—

3 “(A) IN GENERAL.—In order to facilitate
4 the attribution of patients and episodes (in
5 whole or in part) to one or more physicians or
6 applicable practitioners furnishing items and
7 services, the Secretary shall undertake the steps
8 described in the succeeding provisions of this
9 paragraph.

10 “(B) DEVELOPMENT OF PATIENT RELA-
11 TIONSHIP CATEGORIES AND CODES.—The Sec-
12 retary shall develop patient relationship cat-
13 egories and codes that define and distinguish
14 the relationship and responsibility of a physi-
15 cian or applicable practitioner with a patient at
16 the time of furnishing an item or service. Such
17 patient relationship categories shall include dif-
18 ferent relationships of the physician or applica-
19 ble practitioner to the patient (and the codes
20 may reflect combinations of such categories),
21 such as a physician or applicable practitioner
22 who—

23 “(i) considers himself to have the
24 primary responsibility for the general and

1 ongoing care for the patient over extended
2 periods of time;

3 “(ii) considers themselves to be the lead
4 physician or practitioner and who furnishes
5 items and services and coordinates care
6 furnished by other physicians or practi-
7 tioners for the patient during an acute epi-
8 sode;

9 “(iii) furnishes items and services to
10 the patient on a continuing basis during an
11 acute episode of care, but in a supportive
12 rather than a lead role;

13 “(iv) furnishes items and services to
14 the patient on an occasional basis, usually
15 at the request of another physician or
16 practitioner; or

17 “(v) furnishes items and services only
18 as ordered by another physician or practi-
19 tioner.

20 “(C) DRAFT LIST OF PATIENT RELATION-
21 SHIP CATEGORIES AND CODES.—Not later than
22 270 days after the date of the enactment of this
23 subsection, the Secretary shall post on the
24 Internet website of the Centers for Medicare &
25 Medicaid Services a draft list of the patient re-

1 relationship categories and codes developed under
2 subparagraph (B).

3 “(D) STAKEHOLDER INPUT.—The Sec-
4 retary shall seek, through the date that is 60
5 days after the Secretary posts the list pursuant
6 to subparagraph (C), comments from physician
7 specialty societies, applicable practitioner orga-
8 nizations, and other stakeholders, including rep-
9 resentatives of individuals entitled to benefits
10 under part A or enrolled under this part, re-
11 garding the patient relationship categories and
12 codes posted under subparagraph (C). In seek-
13 ing such comments, the Secretary shall use one
14 or more mechanisms (other than notice and
15 comment rulemaking) that may include open
16 door forums, town hall meetings, or other ap-
17 propriate mechanisms.

18 “(E) OPERATIONAL LIST OF PATIENT RE-
19 LATIONSHIP CATEGORIES AND CODES.—Not
20 later than 180 days after the end of the com-
21 ment period described in subparagraph (D),
22 taking into account the comments received
23 under such subparagraph, the Secretary shall
24 post on the Internet website of the Centers for

1 Medicare & Medicaid Services an operational
2 list of patient relationship categories and codes.

3 “(F) SUBSEQUENT REVISIONS.—Not later
4 than November 1 of each year (beginning with
5 2017), the Secretary shall, through rulemaking,
6 make revisions to the operational list of patient
7 relationship categories and codes as the Sec-
8 retary determines appropriate. Such revisions
9 may be based on experience, new information
10 developed pursuant to subsection (n)(9)(A), and
11 input from the physician specialty societies, ap-
12 plicable practitioner organizations, and other
13 stakeholders, including representatives of indi-
14 viduals entitled to benefits under part A or en-
15 rolled under this part.

16 “(4) REPORTING OF INFORMATION FOR RE-
17 SOURCE USE MEASUREMENT.—Claims submitted for
18 items and services furnished by a physician or appli-
19 cable practitioner on or after January 1, 2017, shall,
20 as determined appropriate by the Secretary, in-
21 clude—

22 “(A) applicable codes established under
23 paragraphs (2) and (3); and

24 “(B) the national provider identifier of the
25 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

1 respect to patients attributed to physicians and
2 applicable practitioners, the Secretary shall, as
3 feasible—

4 “(i) use the claims data experience of
5 such patients by patient condition codes
6 during a common period, such as 12
7 months; and

8 “(ii) use the claims data experience of
9 such patients by care episode codes—

10 “(I) in the case of episodes with-
11 out a hospitalization, during periods
12 of time (such as the number of days)
13 determined appropriate by the Sec-
14 retary; and

15 “(II) in the case of episodes with
16 a hospitalization, during periods of
17 time (such as the number of days) be-
18 fore, during, and after the hospitaliza-
19 tion.

20 “(C) MEASUREMENT OF RESOURCE USE.—

21 In measuring such resource use, the Sec-
22 retary—

23 “(i) shall use per patient total allowed
24 charges for all services under part A and
25 this part (and, if the Secretary determines

1 appropriate, part D) for the analysis of pa-
2 tient resource use, by care episode codes
3 and by patient condition codes; and

4 “(ii) may, as determined appropriate,
5 use other measures of allowed charges
6 (such as subtotals for categories of items
7 and services) and measures of utilization of
8 items and services (such as frequency of
9 specific items and services and the ratio of
10 specific items and services among attrib-
11 uted patients or episodes).

12 “(D) STAKEHOLDER INPUT.—The Sec-
13 retary shall seek comments from the physician
14 specialty societies, applicable practitioner orga-
15 nizations, and other stakeholders, including rep-
16 resentatives of individuals entitled to benefits
17 under part A or enrolled under this part, re-
18 garding the resource use methodology estab-
19 lished pursuant to this paragraph. In seeking
20 comments the Secretary shall use one or more
21 mechanisms (other than notice and comment
22 rulemaking) that may include open door fo-
23 rums, town hall meetings, or other appropriate
24 mechanisms.

1 “(6) IMPLEMENTATION.—To the extent that
2 the Secretary contracts with an entity to carry out
3 any part of the provisions of this subsection, the
4 Secretary may not contract with an entity or an en-
5 tity with a subcontract if the entity or subcon-
6 tracting entity currently makes recommendations to
7 the Secretary on relative values for services under
8 the fee schedule for physicians’ services under this
9 section.

10 “(7) LIMITATION.—There shall be no adminis-
11 trative or judicial review under section 1869, section
12 1878, or otherwise of—

13 “(A) care episode and patient condition
14 groups and codes established under paragraph
15 (2);

16 “(B) patient relationship categories and
17 codes established under paragraph (3); and

18 “(C) measurement of, and analyses of re-
19 source use with respect to, care episode and pa-
20 tient condition codes and patient relationship
21 codes pursuant to paragraph (5).

22 “(8) ADMINISTRATION.—Chapter 35 of title 44,
23 United States Code, shall not apply to this section.

24 “(9) DEFINITIONS.—In this section:

1 “(A) PHYSICIAN.—The term ‘physician’
 2 has the meaning given such term in section
 3 1861(r)(1).

4 “(B) APPLICABLE PRACTITIONER.—The
 5 term ‘applicable practitioner’ means—

6 “(i) a physician assistant, nurse prac-
 7 titioner, and clinical nurse specialist (as
 8 such terms are defined in section
 9 1861(aa)(5)), and a certified registered
 10 nurse anesthetist (as defined in section
 11 1861(bb)(2)); and

12 “(ii) beginning January 1, 2018, such
 13 other eligible professionals (as defined in
 14 subsection (k)(3)(B)) as specified by the
 15 Secretary.

16 “(10) CLARIFICATION.—The provisions of sec-
 17 tions 1890(b)(7) and 1890A shall not apply to this
 18 subsection.”.

19 **SEC. 3. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**
 20 **OPMENT.**

21 Section 1848 of the Social Security Act (42 U.S.C.
 22 1395w-4), as amended by subsections (c) and (g) of sec-
 23 tion 2, is further amended by inserting at the end the fol-
 24 lowing new subsection:

1 “(s) PRIORITIES AND FUNDING FOR MEASURE DE-
2 VELOPMENT.—

3 “(1) PLAN IDENTIFYING MEASURE DEVELOP-
4 MENT PRIORITIES AND TIMELINES.—

5 “(A) DRAFT MEASURE DEVELOPMENT
6 PLAN.—Not later than January 1, 2015, the
7 Secretary shall develop, and post on the Inter-
8 net website of the Centers for Medicare & Med-
9 icaid Services, a draft plan for the development
10 of quality measures for application under the
11 applicable provisions (as defined in paragraph
12 (5)). Under such plan the Secretary shall—

13 “(i) address how measures used by
14 private payers and integrated delivery sys-
15 tems could be incorporated under title
16 XVIII;

17 “(ii) describe how coordination, to the
18 extent possible, will occur across organiza-
19 tions developing such measures; and

20 “(iii) take into account how clinical
21 best practices and clinical practice guide-
22 lines should be used in the development of
23 quality measures.

1 “(B) QUALITY DOMAINS.—For purposes of
2 this subsection, the term ‘quality domains’
3 means at least the following domains:

4 “(i) Clinical care.

5 “(ii) Safety.

6 “(iii) Care coordination.

7 “(iv) Patient and caregiver experience.

8 “(v) Population health and preven-
9 tion.

10 “(C) CONSIDERATION.—In developing the
11 draft plan under this paragraph, the Secretary
12 shall consider—

13 “(i) gap analyses conducted by the en-
14 tity with a contract under section 1890(a)
15 or other contractors or entities;

16 “(ii) whether measures are applicable
17 across health care settings;

18 “(iii) clinical practice improvement ac-
19 tivities submitted under subsection
20 (q)(2)(C)(iv) for identifying possible areas
21 for future measure development and identi-
22 fying existing gaps with respect to such
23 measures; and

24 “(iv) the quality domains applied
25 under this subsection.

1 “(D) PRIORITIES.—In developing the draft
2 plan under this paragraph, the Secretary shall
3 give priority to the following types of measures:

4 “(i) Outcome measures, including pa-
5 tient reported outcome and functional sta-
6 tus measures.

7 “(ii) Patient experience measures.

8 “(iii) Care coordination measures.

9 “(iv) Measures of appropriate use of
10 services, including measures of over use.

11 “(E) STAKEHOLDER INPUT.—The Sec-
12 retary shall accept through March 1, 2015,
13 comments on the draft plan posted under para-
14 graph (1)(A) from the public, including health
15 care providers, payers, consumers, and other
16 stakeholders.

17 “(F) FINAL MEASURE DEVELOPMENT
18 PLAN.—Not later than May 1, 2015, taking
19 into account the comments received under this
20 subparagraph, the Secretary shall finalize the
21 plan and post on the Internet website of the
22 Centers for Medicare & Medicaid Services an
23 operational plan for the development of quality
24 measures for use under the applicable provi-

1 sions. Such plan shall be updated as appro-
2 prium.

3 “(2) CONTRACTS AND OTHER ARRANGEMENTS
4 FOR QUALITY MEASURE DEVELOPMENT.—

5 “(A) IN GENERAL.—The Secretary shall
6 enter into contracts or other arrangements with
7 entities for the purpose of developing, improv-
8 ing, updating, or expanding in accordance with
9 the plan under paragraph (1) quality measures
10 for application under the applicable provisions.
11 Such entities shall include organizations with
12 quality measure development expertise.

13 “(B) PRIORITIZATION.—

14 “(i) IN GENERAL.—In entering into
15 contracts or other arrangements under
16 subparagraph (A), the Secretary shall give
17 priority to the development of the types of
18 measures described in paragraph (1)(D).

19 “(ii) CONSIDERATION.—In selecting
20 measures for development under this sub-
21 section, the Secretary shall consider—

22 “(I) whether such measures
23 would be electronically specified; and

1 “(II) clinical practice guidelines
2 to the extent that such guidelines
3 exist.

4 “(3) ANNUAL REPORT BY THE SECRETARY.—

5 “(A) IN GENERAL.—Not later than May 1,
6 2016, and annually thereafter, the Secretary
7 shall post on the Internet website of the Cen-
8 ters for Medicare & Medicaid Services a report
9 on the progress made in developing quality
10 measures for application under the applicable
11 provisions.

12 “(B) REQUIREMENTS.—Each report sub-
13 mitted pursuant to subparagraph (A) shall in-
14 clude the following:

15 “(i) A description of the Secretary’s
16 efforts to implement this paragraph.

17 “(ii) With respect to the measures de-
18 veloped during the previous year—

19 “(I) a description of the total
20 number of quality measures developed
21 and the types of such measures, such
22 as an outcome or patient experience
23 measure;

24 “(II) the name of each measure
25 developed;

1 “(III) the name of the developer
2 and steward of each measure;

3 “(IV) with respect to each type
4 of measure, an estimate of the total
5 amount expended under this title to
6 develop all measures of such type; and

7 “(V) whether the measure would
8 be electronically specified.

9 “(iii) With respect to measures in de-
10 velopment at the time of the report—

11 “(I) the information described in
12 clause (ii), if available; and

13 “(II) a timeline for completion of
14 the development of such measures.

15 “(iv) A description of any updates to
16 the plan under paragraph (1) (including
17 newly identified gaps and the status of pre-
18 viously identified gaps) and the inventory
19 of measures applicable under the applicable
20 provisions.

21 “(v) Other information the Secretary
22 determines to be appropriate.

23 “(4) STAKEHOLDER INPUT.—With respect to
24 paragraph (1), the Secretary shall seek stakeholder
25 input with respect to—

1 “(A) the identification of gaps where no
 2 quality measures exist, particularly with respect
 3 to the types of measures described in paragraph
 4 (1)(D);

5 “(B) prioritizing quality measure develop-
 6 ment to address such gaps; and

7 “(C) other areas related to quality measure
 8 development determined appropriate by the Sec-
 9 retary.

10 “(5) DEFINITION OF APPLICABLE PROVI-
 11 SIONS.—In this subsection, the term ‘applicable pro-
 12 visions’ means the following provisions:

13 “(A) Subsection (q)(2)(B)(i).

14 “(B) Section 1833(z)(2)(C).

15 “(6) FUNDING.—For purposes of carrying out
 16 this subsection, the Secretary shall provide for the
 17 transfer, from the Federal Supplementary Medical
 18 Insurance Trust Fund under section 1841, of
 19 \$15,000,000 to the Centers for Medicare & Medicaid
 20 Services Program Management Account for each of
 21 fiscal years 2014 through 2018. Amounts trans-
 22 ferred under this paragraph shall remain available
 23 through the end of fiscal year 2021.”.

1 **SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVID-**
 2 **UALS WITH CHRONIC CARE NEEDS.**

3 (a) IN GENERAL.—Section 1848(b) of the Social Se-
 4 curity Act (42 U.S.C. 1395w–4(b)) is amended by adding
 5 at the end the following new paragraph:

6 “(8) ENCOURAGING CARE MANAGEMENT FOR
 7 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

8 “(A) IN GENERAL.—In order to encourage
 9 the management of care by an applicable pro-
 10 vider (as defined in subparagraph (B)) for indi-
 11 viduals with chronic care needs the Secretary
 12 shall—

13 “(i) establish one or more HCPCS
 14 codes for chronic care management serv-
 15 ices for such individuals; and

16 “(ii) subject to subparagraph (D),
 17 make payment (as the Secretary deter-
 18 mines to be appropriate) under this section
 19 for such management services furnished on
 20 or after January 1, 2015, by an applicable
 21 provider.

22 “(B) APPLICABLE PROVIDER DEFINED.—
 23 For purposes of this paragraph, the term ‘ap-
 24 plicable provider’ means a physician (as defined
 25 in section 1861(r)(1)), physician assistant or
 26 nurse practitioner (as defined in section

1 1861(aa)(5)(A)), or clinical nurse specialist (as
2 defined in section 1861(aa)(5)(B)) who fur-
3 nishes services as part of a patient-centered
4 medical home or a comparable specialty practice
5 that—

6 “(i) is recognized as such a medical
7 home or comparable specialty practice by
8 an organization that is recognized by the
9 Secretary for purposes of such recognition
10 as such a medical home or practice; or

11 “(ii) meets such other comparable
12 qualifications as the Secretary determines
13 to be appropriate.

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

18 “(D) POLICIES RELATING TO PAYMENT.—
19 In carrying out this paragraph, with respect to
20 chronic care management services, the Sec-
21 retary shall—

22 “(i) make payment to only one appli-
23 cable provider for such services furnished
24 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.”.

(b) EDUCATION AND OUTREACH.—

(1) CAMPAIGN.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act, as added by subsection (a),

1 and encourage such individuals with chronic
2 care needs to receive such services.

3 (B) REQUIREMENTS.—Such campaign
4 shall—

5 (i) be directed by the Office of Rural
6 Health Policy of the Department of Health
7 and Human Services and the Office of Mi-
8 nority Health of the Centers for Medicare
9 & Medicaid Services; and

10 (ii) focus on encouraging participation
11 by underserved rural populations and ra-
12 cial and ethnic minority populations.

13 (2) REPORT.—

14 (A) IN GENERAL.—Not later than Decem-
15 ber 31, 2017, the Secretary shall submit to
16 Congress a report on the use of chronic care
17 management services described in such section
18 1848(b)(8) by individuals living in rural areas
19 and by racial and ethnic minority populations.
20 Such report shall—

21 (i) identify barriers to receiving chron-
22 ic care management services; and

23 (ii) make recommendations for in-
24 creasing the appropriate use of chronic
25 care management services.

1 **SEC. 5. ENSURING ACCURATE VALUATION OF SERVICES**
2 **UNDER THE PHYSICIAN FEE SCHEDULE.**

3 (a) AUTHORITY TO COLLECT AND USE INFORMA-
4 TION ON PHYSICIANS' SERVICES IN THE DETERMINATION
5 OF RELATIVE VALUES.—

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

10 “(M) AUTHORITY TO COLLECT AND USE
11 INFORMATION ON PHYSICIANS' SERVICES IN
12 THE DETERMINATION OF RELATIVE VALUES.—

13 “(i) COLLECTION OF INFORMATION.—
14 Notwithstanding any other provision of
15 law, the Secretary may collect or obtain in-
16 formation on the resources directly or indi-
17 rectly related to furnishing services for
18 which payment is made under the fee
19 schedule established under subsection (b).
20 Such information may be collected or ob-
21 tained from any eligible professional or any
22 other source.

23 “(ii) USE OF INFORMATION.—Not-
24 withstanding any other provision of law,
25 subject to clause (v), the Secretary may
26 (as the Secretary determines appropriate)

1 use information collected or obtained pur-
2 suant to clause (i) in the determination of
3 relative values for services under this sec-
4 tion.

5 “(iii) TYPES OF INFORMATION.—The
6 types of information described in clauses
7 (i) and (ii) may, at the Secretary’s discre-
8 tion, include any or all of the following:

9 “(I) Time involved in furnishing
10 services.

11 “(II) Amounts and types of prac-
12 tice expense inputs involved with fur-
13 nishing services.

14 “(III) Prices (net of any dis-
15 counts) for practice expense inputs,
16 which may include paid invoice prices
17 or other documentation or records.

18 “(IV) Overhead and accounting
19 information for practices of physicians
20 and other suppliers.

21 “(V) Any other element that
22 would improve the valuation of serv-
23 ices under this section.

24 “(iv) INFORMATION COLLECTION
25 MECHANISMS.—Information may be col-

1 lected or obtained pursuant to this sub-
2 paragraph from any or all of the following:

3 “(I) Surveys of physicians, other
4 suppliers, providers of services, manu-
5 facturers, and vendors.

6 “(II) Surgical logs, billing sys-
7 tems, or other practice or facility
8 records.

9 “(III) Electronic health records.

10 “(IV) Any other mechanism de-
11 termined appropriate by the Sec-
12 retary.

13 “(v) TRANSPARENCY OF USE OF IN-
14 FORMATION.—

15 “(I) IN GENERAL.—Subject to
16 subclauses (II) and (III), if the Sec-
17 retary uses information collected or
18 obtained under this subparagraph in
19 the determination of relative values
20 under this subsection, the Secretary
21 shall disclose the information source
22 and discuss the use of such informa-
23 tion in such determination of relative
24 values through notice and comment
25 rulemaking.

1 “(II) THRESHOLDS FOR USE.—

2 The Secretary may establish thresh-
3 olds in order to use such information,
4 including the exclusion of information
5 collected or obtained from eligible pro-
6 fessionals who use very high resources
7 (as determined by the Secretary) in
8 furnishing a service.

9 “(III) DISCLOSURE OF INFORMA-
10 TION.—The Secretary shall make ag-
11 gregate information available under
12 this subparagraph but shall not dis-
13 close information in a form or manner
14 that identifies an eligible professional
15 or a group practice, or information
16 collected or obtained pursuant to a
17 nondisclosure agreement.

18 “(vi) INCENTIVE TO PARTICIPATE.—

19 The Secretary may provide for such pay-
20 ments under this part to an eligible profes-
21 sional that submits such solicited informa-
22 tion under this subparagraph as the Sec-
23 retary determines appropriate in order to
24 compensate such eligible professional for
25 such submission. Such payments shall be

1 provided in a form and manner specified
2 by the Secretary.

3 “(vii) ADMINISTRATION.—Chapter 35
4 of title 44, United States Code, shall not
5 apply to information collected or obtained
6 under this subparagraph.

7 “(viii) DEFINITION OF ELIGIBLE PRO-
8 FESSIOAL.—In this subparagraph, the
9 term ‘eligible professional’ has the meaning
10 given such term in subsection (k)(3)(B).

11 “(ix) FUNDING.—For purposes of car-
12 rying out this subparagraph, in addition to
13 funds otherwise appropriated, the Sec-
14 retary shall provide for the transfer, from
15 the Federal Supplementary Medical Insur-
16 ance Trust Fund under section 1841, of
17 \$2,000,000 to the Centers for Medicare &
18 Medicaid Services Program Management
19 Account for each fiscal year beginning with
20 fiscal year 2014. Amounts transferred
21 under the preceding sentence for a fiscal
22 year shall be available until expended.”.

23 (2) LIMITATION ON REVIEW.—Section
24 1848(i)(1) of the Social Security Act (42 U.S.C.
25 1395w-4(i)(1)) is amended—

1 (A) in subparagraph (D), by striking
2 “and” at the end;

3 (B) in subparagraph (E), by striking the
4 period at the end and inserting “, and”; and

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

7 “(F) the collection and use of information
8 in the determination of relative values under
9 subsection (c)(2)(M).”.

10 (b) AUTHORITY FOR ALTERNATIVE APPROACHES TO
11 ESTABLISHING PRACTICE EXPENSE RELATIVE VAL-
12 UES.—Section 1848(c)(2) of the Social Security Act (42
13 U.S.C. 1395w-4(c)(2)), as amended by subsection (a), is
14 amended by adding at the end the following new subpara-
15 graph:

16 “(N) AUTHORITY FOR ALTERNATIVE AP-
17 PROACHES TO ESTABLISHING PRACTICE EX-
18 PENSE RELATIVE VALUES.—The Secretary may
19 establish or adjust practice expense relative val-
20 ues under this subsection using cost, charge, or
21 other data from suppliers or providers of serv-
22 ices, including information collected or obtained
23 under subparagraph (M).”.

24 (c) REVISED AND EXPANDED IDENTIFICATION OF
25 POTENTIALLY MISVALUED CODES.—Section

1 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.
2 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

3 “(ii) IDENTIFICATION OF POTEN-
4 Tially MISVALUED CODES.—For purposes
5 of identifying potentially misvalued codes
6 pursuant to clause (i)(I), the Secretary
7 shall examine codes (and families of codes
8 as appropriate) based on any or all of the
9 following criteria:

10 “(I) Codes that have experienced
11 the fastest growth.

12 “(II) Codes that have experi-
13 enced substantial changes in practice
14 expenses.

15 “(III) Codes that describe new
16 technologies or services within an ap-
17 propriate time period (such as 3
18 years) after the relative values are ini-
19 tially established for such codes.

20 “(IV) Codes which are multiple
21 codes that are frequently billed in con-
22 junction with furnishing a single serv-
23 ice.

24 “(V) Codes with low relative val-
25 ues, particularly those that are often

1 billed multiple times for a single treat-
2 ment.

3 “(VI) Codes that have not been
4 subject to review since implementation
5 of the fee schedule.

6 “(VII) Codes that account for
7 the majority of spending under the
8 physician fee schedule.

9 “(VIII) Codes for services that
10 have experienced a substantial change
11 in the hospital length of stay or proce-
12 dure time.

13 “(IX) Codes for which there may
14 be a change in the typical site of serv-
15 ice since the code was last valued.

16 “(X) Codes for which there is a
17 significant difference in payment for
18 the same service between different
19 sites of service.

20 “(XI) Codes for which there may
21 be anomalies in relative values within
22 a family of codes.

23 “(XII) Codes for services where
24 there may be efficiencies when a serv-

1 ice is furnished at the same time as
2 other services.

3 “(XIII) Codes with high intra-
4 service work per unit of time.

5 “(XIV) Codes with high practice
6 expense relative value units.

7 “(XV) Codes with high cost sup-
8 plies.

9 “(XVI) Codes as determined ap-
10 propriate by the Secretary.”.

11 (d) TARGET FOR RELATIVE VALUE ADJUSTMENTS
12 FOR MISVALUED SERVICES.—

13 (1) IN GENERAL.—Section 1848(c)(2) of the
14 Social Security Act (42 U.S.C. 1395w–4(c)(2)), as
15 amended by subsections (a) and (b), is amended by
16 adding at the end the following new subparagraph:

17 “(O) TARGET FOR RELATIVE VALUE AD-
18 JUSTMENTS FOR MISVALUED SERVICES.—With
19 respect to fee schedules established for each of
20 2015 through 2018, the following shall apply:

21 “(i) DETERMINATION OF NET REDUC-
22 TION IN EXPENDITURES.—For each year,
23 the Secretary shall determine the esti-
24 mated net reduction in expenditures under
25 the fee schedule under this section with re-

1 spect to the year as a result of adjust-
2 ments to the relative values established
3 under this paragraph for misvalued codes.

4 “(ii) BUDGET NEUTRAL REDISTRIBU-
5 TION OF FUNDS IF TARGET MET AND
6 COUNTING OVERAGES TOWARDS THE TAR-
7 GET FOR THE SUCCEEDING YEAR.—If the
8 estimated net reduction in expenditures de-
9 termined under clause (i) for the year is
10 equal to or greater than the target for the
11 year—

12 “(I) reduced expenditures attrib-
13 utable to such adjustments shall be
14 redistributed for the year in a budget
15 neutral manner in accordance with
16 subparagraph (B)(ii)(II); and

17 “(II) the amount by which such
18 reduced expenditures exceeds the tar-
19 get for the year shall be treated as a
20 reduction in expenditures described in
21 clause (i) for the succeeding year, for
22 purposes of determining whether the
23 target has or has not been met under
24 this subparagraph with respect to that
25 year.

1 “(iii) EXEMPTION FROM BUDGET
2 NEUTRALITY IF TARGET NOT MET.—If the
3 estimated net reduction in expenditures de-
4 termined under clause (i) for the year is
5 less than the target for the year, reduced
6 expenditures in an amount equal to the
7 target recapture amount shall not be taken
8 into account in applying subparagraph
9 (B)(ii)(II) with respect to fee schedules be-
10 ginning with 2015.

11 “(iv) TARGET RECAPTURE AMOUNT.—
12 For purposes of clause (iii), the target re-
13 capture amount is, with respect to a year,
14 an amount equal to the difference be-
15 tween—

16 “(I) the target for the year; and
17 “(II) the estimated net reduction
18 in expenditures determined under
19 clause (i) for the year.

20 “(v) TARGET.—For purposes of this
21 subparagraph, with respect to a year, the
22 target is calculated as 0.5 percent of the
23 estimated amount of expenditures under
24 the fee schedule under this section for the
25 year.”.

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

5 “(VIII) REDUCTIONS FOR
 6 MISVALUED SERVICES IF TARGET NOT
 7 MET.—Effective for fee schedules be-
 8 ginning with 2015, reduced expendi-
 9 tures attributable to the application of
 10 the target recapture amount described
 11 in subparagraph (O)(iii).”.

12 (e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE
 13 UNIT (RVU) REDUCTIONS.—

14 (1) IN GENERAL.—Section 1848(c) of the So-
 15 cial Security Act (42 U.S.C. 1395w–4(c)) is amend-
 16 ed by adding at the end the following new para-
 17 graph:

18 “(7) PHASE-IN OF SIGNIFICANT RELATIVE
 19 VALUE UNIT (RVU) REDUCTIONS.—Effective for fee
 20 schedules established beginning with 2015, if the
 21 total relative value units for a service for a year
 22 would otherwise be decreased by an estimated
 23 amount equal to or greater than 20 percent as com-
 24 pared to the total relative value units for the pre-
 25 vious year, the applicable adjustments in work, prac-

1 tice expense, and malpractice relative value units
 2 shall be phased-in over a 2-year period.”.

3 (2) CONFORMING AMENDMENTS.—Section
 4 1848(c)(2) of the Social Security Act (42 U.S.C.
 5 1395w-4(c)(2)) is amended—

6 (A) in subparagraph (B)(ii)(I), by striking
 7 “subclause (II)” and inserting “subclause (II)
 8 and paragraph (7)”; and

9 (B) in subparagraph (K)(iii)(VI)—

10 (i) by striking “provisions of subpara-
 11 graph (B)(ii)(II)” and inserting “provi-
 12 sions of subparagraph (B)(ii)(II) and para-
 13 graph (7)”; and

14 (ii) by striking “under subparagraph
 15 (B)(ii)(II)” and inserting “under subpara-
 16 graph (B)(ii)(I)”.

17 (f) AUTHORITY TO SMOOTH RELATIVE VALUES
 18 WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of
 19 the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)) is
 20 amended—

21 (1) in each of clauses (i) and (iii), by striking
 22 “the service” and inserting “the service or group of
 23 services” each place it appears; and

24 (2) in the first sentence of clause (ii), by insert-
 25 ing “or group of services” before the period.

1 (g) GAO STUDY AND REPORT ON RELATIVE VALUE
2 SCALE UPDATE COMMITTEE.—

3 (1) STUDY.—The Comptroller General of the
4 United States (in this subsection referred to as the
5 “Comptroller General”) shall conduct a study of the
6 processes used by the Relative Value Scale Update
7 Committee (RUC) to provide recommendations to
8 the Secretary of Health and Human Services regard-
9 ing relative values for specific services under the
10 Medicare physician fee schedule under section 1848
11 of the Social Security Act (42 U.S.C. 1395w–4).

12 (2) REPORT.—Not later than 1 year after the
13 date of the enactment of this Act, the Comptroller
14 General shall submit to Congress a report containing
15 the results of the study conducted under paragraph
16 (1).

17 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-
18 ITIES.—

19 (1) IN GENERAL.—Section 1848(e) of the So-
20 cial Security Act (42 U.S.C. 1395w–4(e)) is amend-
21 ed by adding at the end the following new para-
22 graph:

23 “(6) USE OF MSAS AS FEE SCHEDULE AREAS IN
24 CALIFORNIA.—

1 “(A) IN GENERAL.—Subject to the suc-
2 ceeding provisions of this paragraph and not-
3 withstanding the previous provisions of this
4 subsection, for services furnished on or after
5 January 1, 2017, the fee schedule areas used
6 for payment under this section applicable to
7 California shall be the following:

8 “(i) Each Metropolitan Statistical
9 Area (each in this paragraph referred to as
10 an ‘MSA’), as defined by the Director of
11 the Office of Management and Budget as
12 of December 31 of the previous year, shall
13 be a fee schedule area.

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

17 “(B) TRANSITION FOR MSAS PREVIOUSLY
18 IN REST-OF-STATE PAYMENT LOCALITY OR IN
19 LOCALITY 3.—

20 “(i) IN GENERAL.—For services fur-
21 nished in California during a year begin-
22 ning with 2017 and ending with 2021 in
23 an MSA in a transition area (as defined in
24 subparagraph (D)), subject to subpara-
25 graph (C), the geographic index values to

1 be applied under this subsection for such
2 year shall be equal to the sum of the fol-
3 lowing:

4 “(I) CURRENT LAW COMPO-
5 NENT.—The old weighting factor (de-
6 scribed in clause (ii)) for such year
7 multiplied by the geographic index
8 values under this subsection for the
9 fee schedule area that included such
10 MSA that would have applied in such
11 area (as estimated by the Secretary)
12 if this paragraph did not apply.

13 “(II) MSA-BASED COMPO-
14 NENT.—The MSA-based weighting
15 factor (described in clause (iii)) for
16 such year multiplied by the geographic
17 index values computed for the fee
18 schedule area under subparagraph (A)
19 for the year (determined without re-
20 gard to this subparagraph).

21 “(ii) OLD WEIGHTING FACTOR.—The
22 old weighting factor described in this
23 clause—

24 “(I) for 2017, is $\frac{5}{6}$; and

1 “(II) for each succeeding year, is
2 the old weighting factor described in
3 this clause for the previous year
4 minus $\frac{1}{6}$.

5 “(iii) MSA-BASED WEIGHTING FAC-
6 TOR.—The MSA-based weighting factor
7 described in this clause for a year is 1
8 minus the old weighting factor under
9 clause (ii) for that year.

10 “(C) HOLD HARMLESS.—For services fur-
11 nished in a transition area in California during
12 a year beginning with 2017, the geographic
13 index values to be applied under this subsection
14 for such year shall not be less than the cor-
15 responding geographic index values that would
16 have applied in such transition area (as esti-
17 mated by the Secretary) if this paragraph did
18 not apply.

19 “(D) TRANSITION AREA DEFINED.—In
20 this paragraph, the term ‘transition area’
21 means each of the following fee schedule areas
22 for 2013:

23 “(i) The rest-of-State payment local-
24 ity.

25 “(ii) Payment locality 3.

1 “(E) REFERENCES TO FEE SCHEDULE
2 AREAS.—Effective for services furnished on or
3 after January 1, 2017, for California, any ref-
4 erence in this section to a fee schedule area
5 shall be deemed a reference to a fee schedule
6 area established in accordance with this para-
7 graph.”.

8 (2) CONFORMING AMENDMENT TO DEFINITION
9 OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the
10 Social Security Act (42 U.S.C. 1395w–4(j)(2)) is
11 amended by striking “The term” and inserting “Ex-
12 cept as provided in subsection (e)(6)(D), the term”.

13 (i) DISCLOSURE OF DATA USED TO ESTABLISH
14 MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—
15 The Secretary of Health and Human Services shall make
16 publicly available the information used to establish the
17 multiple procedure payment reduction policy to the profes-
18 sional component of imaging services in the final rule pub-
19 lished in the Federal Register, v. 77, n. 222, November
20 16, 2012, pages 68891–69380 under the physician fee
21 schedule under section 1848 of the Social Security Act (42
22 U.S.C. 1395w–4).

1 **SEC. 6. PROMOTING EVIDENCE-BASED CARE.**

2 (a) IN GENERAL.—Section 1834 of the Social Secu-
3 rity Act (42 U.S.C. 1395m) is amended by adding at the
4 end the following new subsection:

5 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR
6 CERTAIN IMAGING SERVICES.—

7 “(1) PROGRAM ESTABLISHED.—

8 “(A) IN GENERAL.—The Secretary shall
9 establish a program to promote the use of ap-
10 propriate use criteria (as defined in subpara-
11 graph (B)) for applicable imaging services (as
12 defined in subparagraph (C)) furnished in an
13 applicable setting (as defined in subparagraph
14 (D)) by ordering professionals and furnishing
15 professionals (as defined in subparagraphs (E)
16 and (F), respectively).

17 “(B) APPROPRIATE USE CRITERIA DE-
18 FINED.—In this subsection, the term ‘appro-
19 priate use criteria’ means criteria, only devel-
20 oped or endorsed by national professional med-
21 ical specialty societies or other provider-led enti-
22 ties, to assist ordering professionals and fur-
23 nishing professionals in making the most appro-
24 priate treatment decision for a specific clinical
25 condition. To the extent feasible, such criteria
26 shall be evidence-based.

1 “(C) APPLICABLE IMAGING SERVICE DE-
2 FINED.—In this subsection, the term ‘applicable
3 imaging service’ means an advanced diagnostic
4 imaging service (as defined in subsection
5 (e)(1)(B)) for which the Secretary determines—

6 “(i) one or more applicable appro-
7 priate use criteria specified under para-
8 graph (2) apply;

9 “(ii) there are one or more qualified
10 clinical decision support mechanisms listed
11 under paragraph (3)(C); and

12 “(iii) one or more of such mechanisms
13 is available free of charge.

14 “(D) APPLICABLE SETTING DEFINED.—In
15 this subsection, the term ‘applicable setting’
16 means a physician’s office, a hospital outpatient
17 department (including an emergency depart-
18 ment), an ambulatory surgical center, and any
19 other provider-led outpatient setting determined
20 appropriate by the Secretary.

21 “(E) ORDERING PROFESSIONAL DE-
22 FINED.—In this subsection, the term ‘ordering
23 professional’ means a physician (as defined in
24 section 1861(r)) or a practitioner described in

1 section 1842(b)(18)(C) who orders an applica-
2 ble imaging service for an individual.

3 “(F) FURNISHING PROFESSIONAL DE-
4 FINED.—In this subsection, the term ‘fur-
5 nishing professional’ means a physician (as de-
6 fined in section 1861(r)) or a practitioner de-
7 scribed in section 1842(b)(18)(C) who furnishes
8 an applicable imaging service for an individual.

9 “(2) ESTABLISHMENT OF APPLICABLE APPRO-
10 PRIATE USE CRITERIA.—

11 “(A) IN GENERAL.—Not later than No-
12 vember 15, 2015, the Secretary shall through
13 rulemaking, and in consultation with physi-
14 cians, practitioners, and other stakeholders,
15 specify applicable appropriate use criteria for
16 applicable imaging services only from among
17 appropriate use criteria developed or endorsed
18 by national professional medical specialty soci-
19 eties or other provider-led entities.

20 “(B) CONSIDERATIONS.—In specifying ap-
21 plicable appropriate use criteria under subpara-
22 graph (A), the Secretary shall take into account
23 whether the criteria—

24 “(i) have stakeholder consensus;

1 “(ii) are scientifically valid and evi-
2 dence based; and

3 “(iii) are based on studies that are
4 published and reviewable by stakeholders.

5 “(C) REVISIONS.—The Secretary shall re-
6 view, on an annual basis, the specified applica-
7 ble appropriate use criteria to determine if
8 there is a need to update or revise (as appro-
9 priate) such specification of applicable appro-
10 priate use criteria and make such updates or
11 revisions through rulemaking.

12 “(D) TREATMENT OF MULTIPLE APPLICA-
13 BLE APPROPRIATE USE CRITERIA.—In the case
14 where the Secretary determines that more than
15 one appropriate use criteria applies with respect
16 to an applicable imaging service, the Secretary
17 shall permit one or more applicable appropriate
18 use criteria under this paragraph for the serv-
19 ice.

20 “(3) MECHANISMS FOR CONSULTATION WITH
21 APPLICABLE APPROPRIATE USE CRITERIA.—

22 “(A) IDENTIFICATION OF MECHANISMS TO
23 CONSULT WITH APPLICABLE APPROPRIATE USE
24 CRITERIA.—

1 “(i) IN GENERAL.—The Secretary
2 shall specify qualified clinical decision sup-
3 port mechanisms that could be used by or-
4 dering professionals to consult with appli-
5 cable appropriate use criteria for applicable
6 imaging services.

7 “(ii) CONSULTATION.—The Secretary
8 shall consult with physicians, practitioners,
9 health care technology experts, and other
10 stakeholders in specifying mechanisms
11 under this paragraph.

12 “(iii) INCLUSION OF CERTAIN MECHA-
13 NISMS.—Mechanisms specified under this
14 paragraph may include any or all of the
15 following that meet the requirements de-
16 scribed in subparagraph (B)(ii):

17 “(I) Use of clinical decision sup-
18 port modules in certified EHR tech-
19 nology (as defined in section
20 1848(o)(4)).

21 “(II) Use of private sector clin-
22 ical decision support mechanisms that
23 are independent from certified EHR
24 technology, which may include use of
25 clinical decision support mechanisms

1 available from medical specialty orga-
2 nizations.

3 “(III) Use of a clinical decision
4 support mechanism established by the
5 Secretary.

6 “(B) QUALIFIED CLINICAL DECISION SUP-
7 PORT MECHANISMS.—

8 “(i) IN GENERAL.—For purposes of
9 this subsection, a qualified clinical decision
10 support mechanism is a mechanism that
11 the Secretary determines meets the re-
12 quirements described in clause (ii).

13 “(ii) REQUIREMENTS.—The require-
14 ments described in this clause are the fol-
15 lowing:

16 “(I) The mechanism makes avail-
17 able to the ordering professional appli-
18 cable appropriate use criteria specified
19 under paragraph (2) and the sup-
20 porting documentation for the applica-
21 ble imaging service ordered.

22 “(II) In the case where there are
23 more than one applicable appropriate
24 use criteria specified under such para-
25 graph for an applicable imaging serv-

1 ice, the mechanism indicates the cri-
2 teria that it uses for the service.

3 “(III) The mechanism determines
4 the extent to which an applicable im-
5 aging service ordered is consistent
6 with the applicable appropriate use
7 criteria so specified.

8 “(IV) The mechanism generates
9 and provides to the ordering profes-
10 sional a certification or documentation
11 that documents that the qualified clin-
12 ical decision support mechanism was
13 consulted by the ordering professional.

14 “(V) The mechanism is updated
15 on a timely basis to reflect revisions
16 to the specification of applicable ap-
17 propriate use criteria under such
18 paragraph.

19 “(VI) The mechanism meets pri-
20 vacy and security standards under ap-
21 plicable provisions of law.

22 “(VII) The mechanism performs
23 such other functions as specified by
24 the Secretary, which may include a re-

1 requirement to provide aggregate feed-
2 back to the ordering professional.

3 “(C) LIST OF MECHANISMS FOR CON-
4 SULTATION WITH APPLICABLE APPROPRIATE
5 USE CRITERIA.—

6 “(i) INITIAL LIST.—Not later than
7 April 1, 2016, the Secretary shall publish
8 a list of mechanisms specified under this
9 paragraph.

10 “(ii) PERIODIC UPDATING OF LIST.—
11 The Secretary shall identify on an annual
12 basis the list of qualified clinical decision
13 support mechanisms specified under this
14 paragraph.

15 “(4) CONSULTATION WITH APPLICABLE APPRO-
16 PRIATE USE CRITERIA.—

17 “(A) CONSULTATION BY ORDERING PRO-
18 FESSIONAL.—Beginning with January 1, 2017,
19 subject to subparagraph (C), with respect to an
20 applicable imaging service ordered by an order-
21 ing professional that would be furnished in an
22 applicable setting and paid for under an appli-
23 cable payment system (as defined in subpara-
24 graph (D)), an ordering professional shall—

1 “(i) consult with a qualified decision
2 support mechanism listed under paragraph
3 (3)(C); and

4 “(ii) provide to the furnishing profes-
5 sional the information described in clauses
6 (i) through (iii) of subparagraph (B).

7 “(B) REPORTING BY FURNISHING PROFES-
8 SIONAL.—Beginning with January 1, 2017,
9 subject to subparagraph (C), with respect to an
10 applicable imaging service furnished in an ap-
11 plicable setting and paid for under an applica-
12 ble payment system (as defined in subpara-
13 graph (D)), payment for such service may only
14 be made if the claim for the service includes the
15 following:

16 “(i) Information about which qualified
17 clinical decision support mechanism was
18 consulted by the ordering professional for
19 the service.

20 “(ii) Information regarding—

21 “(I) whether the service ordered
22 would adhere to the applicable appro-
23 priate use criteria specified under
24 paragraph (2);

1 “(II) whether the service ordered
2 would not adhere to such criteria; or

3 “(III) whether such criteria was
4 not applicable to the service ordered.

5 “(iii) The national provider identifier
6 of the ordering professional (if different
7 from the furnishing professional).

8 “(C) EXCEPTIONS.—The provisions of sub-
9 paragraphs (A) and (B) and paragraph (6)(A)
10 shall not apply to the following:

11 “(i) EMERGENCY SERVICES.—An ap-
12 plicable imaging service ordered for an in-
13 dividual with an emergency medical condi-
14 tion (as defined in section 1867(e)(1)).

15 “(ii) INPATIENT SERVICES.—An appli-
16 cable imaging service ordered for an inpa-
17 tient and for which payment is made under
18 part A.

19 “(iii) ALTERNATIVE PAYMENT MOD-
20 ELS.—An applicable imaging service or-
21 dered by an ordering professional with re-
22 spect to an individual attributed to an al-
23 ternative payment model (as defined in
24 section 1833(z)(3)(C)).

1 “(iv) SIGNIFICANT HARDSHIP.—An
2 applicable imaging service ordered by an
3 ordering professional who the Secretary
4 may, on a case-by-case basis, exempt from
5 the application of such provisions if the
6 Secretary determines, subject to annual re-
7 newal, that consultation with applicable ap-
8 propriate use criteria would result in a sig-
9 nificant hardship, such as in the case of a
10 professional who practices in a rural area
11 without sufficient Internet access.

12 “(D) APPLICABLE PAYMENT SYSTEM DE-
13 FINED.—In this subsection, the term ‘applicable
14 payment system’ means the following:

15 “(i) The physician fee schedule estab-
16 lished under section 1848(b).

17 “(ii) The prospective payment system
18 for hospital outpatient department services
19 under section 1833(t).

20 “(iii) The ambulatory surgical center
21 payment systems under section 1833(i).

22 “(5) IDENTIFICATION OF OUTLIER ORDERING
23 PROFESSIONALS.—

24 “(A) IN GENERAL.—With respect to appli-
25 cable imaging services furnished beginning with

2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of 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) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

“(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with

1 physicians, practitioners and other stakeholders
2 in developing methods to identify outlier order-
3 ing professionals under this paragraph.

4 “(6) PRIOR AUTHORIZATION FOR ORDERING
5 PROFESSIONALS WHO ARE OUTLIERS.—

6 “(A) IN GENERAL.—Beginning January 1,
7 2020, subject to paragraph (4)(C), with respect
8 to services furnished during a year, the Sec-
9 retary shall, for a period determined appro-
10 priate by the Secretary, apply prior authoriza-
11 tion for applicable imaging services that are or-
12 dered by an outlier ordering professional identi-
13 fied under paragraph (5).

14 “(B) APPROPRIATE USE CRITERIA IN
15 PRIOR AUTHORIZATION.—In applying prior au-
16 thorization under subparagraph (A), the Sec-
17 retary shall utilize only the applicable appro-
18 priate use criteria specified under this sub-
19 section.

20 “(C) FUNDING.—For purposes of carrying
21 out this paragraph, the Secretary shall provide
22 for the transfer, from the Federal Supple-
23 mentary Medical Insurance Trust Fund under
24 section 1841, of \$5,000,000 to the Centers for
25 Medicare & Medicaid Services Program Man-

1 agement Account for each of fiscal years 2019
2 through 2021. Amounts transferred under the
3 preceding sentence shall remain available until
4 expended.

5 “(7) CONSTRUCTION.—Nothing in this sub-
6 section shall be construed as granting the Secretary
7 the authority to develop or initiate the development
8 of clinical practice guidelines or appropriate use cri-
9 teria.”.

10 (b) CONFORMING AMENDMENT.—Section
11 1833(t)(16) of the Social Security Act (42 U.S.C.
12 1395l(t)(16)) is amended by adding at the end the fol-
13 lowing new subparagraph:

14 “(E) APPLICATION OF APPROPRIATE USE
15 CRITERIA FOR CERTAIN IMAGING SERVICES.—
16 For provisions relating to the application of ap-
17 propriate use criteria for certain imaging serv-
18 ices, see section 1834(p).”.

19 (c) REPORT ON EXPERIENCE OF IMAGING APPRO-
20 PRIATE USE CRITERIA PROGRAM.—Not later than 18
21 months after the date of the enactment of this Act, the
22 Comptroller General of the United States shall submit to
23 Congress a report that includes a description of the extent
24 to which appropriate use criteria could be used for other
25 services under part B of title XVIII of the Social Security

1 Act (42 U.S.C. 1395j et seq.), such as radiation therapy
2 and clinical diagnostic laboratory services.

3 **SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH**
4 **ACCESS TO INFORMATION ON PHYSICIANS'**
5 **SERVICES.**

6 (a) IN GENERAL.—The Secretary shall make publicly
7 available on Physician Compare the information described
8 in subsection (b) with respect to eligible professionals.

9 (b) INFORMATION DESCRIBED.—The following infor-
10 mation, with respect to an eligible professional, is de-
11 scribed in this subsection:

12 (1) Information on the number of services fur-
13 nished by the eligible professional under part B of
14 title XVIII of the Social Security Act (42 U.S.C.
15 1395j et seq.), which may include information on the
16 most frequent services furnished or groupings of
17 services.

18 (2) Information on submitted charges and pay-
19 ments for services under such part.

20 (3) A unique identifier for the eligible profes-
21 sional that is available to the public, such as a na-
22 tional provider identifier.

23 (c) SEARCHABILITY.—The information made avail-
24 able under this section shall be searchable by at least the
25 following:

1 (1) The specialty or type of the eligible profes-
2 sional.

3 (2) Characteristics of the services furnished,
4 such as volume or groupings of services.

5 (3) The location of the eligible professional.

6 (d) DISCLOSURE.—The information made available
7 under this section shall indicate, where appropriate, that
8 publicized information may not be representative of the
9 eligible professional's entire patient population, the variety
10 of services furnished by the eligible professional, or the
11 health conditions of individuals treated.

12 (e) IMPLEMENTATION.—

13 (1) INITIAL IMPLEMENTATION.—Physician
14 Compare shall include the information described in
15 subsection (b)—

16 (A) with respect to physicians, by not later
17 than July 1, 2015; and

18 (B) with respect to other eligible profes-
19 sionals, by not later than July 1, 2016.

20 (2) ANNUAL UPDATING.—The information
21 made available under this section shall be updated
22 on Physician Compare not less frequently than on
23 an annual basis.

24 (f) OPPORTUNITY TO REVIEW AND SUBMIT CORREC-
25 TIONS.—The Secretary shall provide for an opportunity

1 for an eligible professional to review, and submit correc-
 2 tions for, the information to be made public with respect
 3 to the eligible professional under this section prior to such
 4 information being made public.

5 (g) DEFINITIONS.—In this section:

6 (1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SEC-
 7 RETARY.—The terms “eligible professional”, “physi-
 8 cian”, and “Secretary” have the meaning given such
 9 terms in section 10331(i) of Public Law 111–148.

10 (2) PHYSICIAN COMPARE.—The term “Physi-
 11 cian Compare” means the Physician Compare Inter-
 12 net website of the Centers for Medicare & Medicaid
 13 Services (or a successor website).

14 **SEC. 8. EXPANDING AVAILABILITY OF MEDICARE DATA.**

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

17 (1) ADDITIONAL ANALYSES.—

18 (A) IN GENERAL.—Subject to subpara-
 19 graph (B), to the extent consistent with appli-
 20 cable information, privacy, security, and disclo-
 21 sure laws (including paragraph (3)), notwith-
 22 standing paragraph (4)(B) of section 1874(e) of
 23 the Social Security Act (42 U.S.C. 1395kk(e))
 24 and the second sentence of paragraph (4)(D) of
 25 such section, beginning July 1, 2015, a quali-

1 fied entity may use the combined data described
2 in paragraph (4)(B)(iii) of such section received
3 by such entity under such section, and informa-
4 tion derived from the evaluation described in
5 such paragraph (4)(D), to conduct additional
6 non-public analyses (as determined appropriate
7 by the Secretary) and provide or sell such anal-
8 yses to authorized users for non-public use (in-
9 cluding for the purposes of assisting providers
10 of services and suppliers to develop and partici-
11 pate in quality and patient care improvement
12 activities, including developing new models of
13 care).

14 (B) LIMITATIONS WITH RESPECT TO ANAL-
15 YSES.—

16 (i) EMPLOYERS.—Any analyses pro-
17 vided or sold under subparagraph (A) to
18 an employer described in paragraph
19 (9)(A)(iii) may only be used by such em-
20 ployer for purposes of providing health in-
21 surance to employees and retirees of the
22 employer.

23 (ii) HEALTH INSURANCE ISSUERS.—A
24 qualified entity may not provide or sell an
25 analysis to a health insurance issuer de-

scribed in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) ACCESS TO CERTAIN DATA.—

(A) ACCESS.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), 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, beginning July 1, 2015, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, in-

cluding for the purposes described in subparagraph (B).

(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) MEDICARE CLAIMS DATA MUST BE PROVIDED AT NO COST.—A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) PROTECTION OF INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individ-

1 ually identifies a patient of such provider or
2 supplier, including with respect to items and
3 services furnished to the patient by other pro-
4 viders of services or suppliers.

5 (C) PROHIBITION ON USING ANALYSES OR
6 DATA FOR MARKETING PURPOSES.—An author-
7 ized user shall not use an analysis or data pro-
8 vided or sold under paragraph (1) or (2) for
9 marketing purposes.

10 (4) DATA USE AGREEMENT.—A qualified entity
11 and an authorized user described in clauses (i), (ii),
12 and (v) of paragraph (9)(A) shall enter into an
13 agreement regarding the use of any data that the
14 qualified entity is providing or selling to the author-
15 ized user under paragraph (2). Such agreement shall
16 describe the requirements for privacy and security of
17 the data and, as determined appropriate by the Sec-
18 retary, any prohibitions on using such data to link
19 to other individually identifiable sources of informa-
20 tion. If the authorized user is not a covered entity
21 under the rules promulgated pursuant to the Health
22 Insurance Portability and Accountability Act of
23 1996, the agreement shall identify the relevant regu-
24 lations, as determined by the Secretary, that the

1 user shall comply with as if it were acting in the ca-
2 pacity of such a covered entity.

3 (5) NO REDISCLOSURE OF ANALYSES OR
4 DATA.—

5 (A) IN GENERAL.—Except as provided in
6 subparagraph (B), an authorized user that is
7 provided or sold an analysis or data under
8 paragraph (1) or (2) shall not redisclose or
9 make public such analysis or data or any anal-
10 ysis using such data.

11 (B) PERMITTED REDISCLOSURE.—A pro-
12 vider of services or supplier that is provided or
13 sold an analysis or data under paragraph (1) or
14 (2) may, as determined by the Secretary, redis-
15 close such analysis or data for the purposes of
16 performance improvement and care coordination
17 activities but shall not make public such anal-
18 ysis or data or any analysis using such data.

19 (6) OPPORTUNITY FOR PROVIDERS OF SERV-
20 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-
21 fied entity providing or selling an analysis to an au-
22 thorized user under paragraph (1), to the extent
23 that such analysis would individually identify a pro-
24 vider of services or supplier who is not being pro-
25 vided or sold such analysis, such qualified entity

1 shall provide such provider or supplier with the op-
2 portunity to appeal and correct errors in the manner
3 described in section 1874(e)(4)(C)(ii) of the Social
4 Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

5 (7) ASSESSMENT FOR A BREACH.—

6 (A) IN GENERAL.—In the case of a breach
7 of a data use agreement under this section or
8 section 1874(e) of the Social Security Act (42
9 U.S.C. 1395kk(e)), the Secretary shall impose
10 an assessment on the qualified entity both in
11 the case of—

12 (i) an agreement between the Sec-
13 retary and a qualified entity; and

14 (ii) an agreement between a qualified
15 entity and an authorized user.

16 (B) ASSESSMENT.—The assessment under
17 subparagraph (A) shall be an amount up to
18 \$100 for each individual entitled to, or enrolled
19 for, benefits under part A of title XVIII of the
20 Social Security Act or enrolled for benefits
21 under part B of such title—

22 (i) in the case of an agreement de-
23 scribed in subparagraph (A)(i), for whom
24 the Secretary provided data on to the
25 qualified entity under paragraph (2); and

1 (ii) in the case of an agreement de-
2 scribed in subparagraph (A)(ii), for whom
3 the qualified entity provided data on to the
4 authorized user under paragraph (2).

5 (C) DEPOSIT OF AMOUNTS COLLECTED.—
6 Any amounts collected pursuant to this para-
7 graph shall be deposited in Federal Supple-
8 mentary Medical Insurance Trust Fund under
9 section 1841 of the Social Security Act (42
10 U.S.C. 1395t).

11 (8) ANNUAL REPORTS.—Any qualified entity
12 that provides or sells an analysis or data under
13 paragraph (1) or (2) shall annually submit to the
14 Secretary a report that includes—

15 (A) a summary of the analyses provided or
16 sold, including the number of such analyses, the
17 number of purchasers of such analyses, and the
18 total amount of fees received for such analyses;

19 (B) a description of the topics and pur-
20 poses of such analyses;

21 (C) information on the entities who re-
22 ceived the data under paragraph (2), the uses
23 of the data, and the total amount of fees re-
24 ceived for providing, selling, or sharing the
25 data; and

1 (D) other information determined appro-
2 priate by the Secretary.

3 (9) DEFINITIONS.—In this subsection and sub-
4 section (b):

5 (A) AUTHORIZED USER.—The term “au-
6 thorized user” means the following:

7 (i) A provider of services.

8 (ii) A supplier.

9 (iii) An employer (as defined in sec-
10 tion 3(5) of the Employee Retirement In-
11 surance Security Act of 1974).

12 (iv) A health insurance issuer (as de-
13 fined in section 2791 of the Public Health
14 Service Act).

15 (v) A medical society or hospital asso-
16 ciation.

17 (vi) Any entity not described in
18 clauses (i) through (v) that is approved by
19 the Secretary (other than an employer or
20 health insurance issuer not described in
21 clauses (iii) and (iv), respectively, as deter-
22 mined by the Secretary).

23 (B) PROVIDER OF SERVICES.—The term
24 “provider of services” has the meaning given

1 such term in section 1861(u) of the Social Se-
2 curity Act (42 U.S.C. 1395x(u)).

3 (C) QUALIFIED ENTITY.—The term “quali-
4 fied entity” has the meaning given such term in
5 section 1874(e)(2) of the Social Security Act
6 (42 U.S.C. 1395kk(e)).

7 (D) SECRETARY.—The term “Secretary”
8 means the Secretary of Health and Human
9 Services.

10 (E) SUPPLIER.—The term “supplier” has
11 the meaning given such term in section 1861(d)
12 of the Social Security Act (42 U.S.C.
13 1395x(d)).

14 (b) ACCESS TO MEDICARE DATA BY QUALIFIED
15 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY
16 IMPROVEMENT.—

17 (1) ACCESS.—

18 (A) IN GENERAL.—To the extent con-
19 sistent with applicable information, privacy, se-
20 curity, and disclosure laws, beginning July 1,
21 2015, the Secretary shall, at the request of a
22 qualified clinical data registry under section
23 1848(m)(3)(E) of the Social Security Act (42
24 U.S.C. 1395w–4(m)(3)(E)), provide the data
25 described in subparagraph (B) (in a form and

1 manner determined to be appropriate) to such
2 qualified clinical data registry for purposes of
3 linking such data with clinical outcomes data
4 and performing risk-adjusted, scientifically valid
5 analyses and research to support quality im-
6 provement or patient safety, provided that any
7 public reporting of such analyses or research
8 that identifies a provider of services or supplier
9 shall only be conducted with the opportunity of
10 such provider or supplier to appeal and correct
11 errors in the manner described in subsection
12 (a)(6).

13 (B) DATA DESCRIBED.—The data de-
14 scribed in this subparagraph is—

15 (i) claims data under the Medicare
16 program under title XVIII of the Social
17 Security Act; and

18 (ii) if the Secretary determines appro-
19 priate, claims data under the Medicaid
20 program under title XIX of such Act and
21 the State Children’s Health Insurance Pro-
22 gram under title XXI of such Act.

23 (2) FEE.—Data described in paragraph (1)(B)
24 shall be provided to a qualified clinical data registry
25 under paragraph (1) at a fee equal to the cost of

1 providing such data. Any fee collected pursuant to
2 the preceding sentence shall be deposited in the Cen-
3 ters for Medicare & Medicaid Services Program
4 Management Account.

5 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED
6 ENTITIES.—Section 1874(e) of the Social Security Act
7 (42 U.S.C. 1395kk(e)) is amended—

8 (1) in the subsection heading, by striking
9 “MEDICARE”; and

10 (2) in paragraph (3)—

11 (A) by inserting after the first sentence the
12 following new sentence: “Beginning July 1,
13 2015, if the Secretary determines appropriate,
14 the data described in this paragraph may also
15 include standardized extracts (as determined by
16 the Secretary) of claims data under titles XIX
17 and XXI for assistance provided under such ti-
18 tles for one or more specified geographic areas
19 and time periods requested by a qualified enti-
20 ty.”; and

21 (B) in the last sentence, by inserting “or
22 under titles XIX or XXI” before the period at
23 the end.

1 (d) REVISION OF PLACEMENT OF FEES.—Section
 2 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
 3 1395kk(e)(4)(A)) is amended, in the second sentence—

4 (1) by inserting “, for periods prior to July 1,
 5 2015,” after “deposited”; and

6 (2) by inserting the following before the period
 7 at the end: “, and, beginning July 1, 2015, into the
 8 Centers for Medicare & Medicaid Services Program
 9 Management Account”.

10 **SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER**
 11 **PROVISIONS.**

12 (a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-
 13 OUT TO PRIVATE CONTRACT.—

14 (1) INDEFINITE, CONTINUING AUTOMATIC EX-
 15 TENSION OF OPT OUT ELECTION.—

16 (A) IN GENERAL.—Section 1802(b)(3) of
 17 the Social Security Act (42 U.S.C. 1395a(b)(3))
 18 is amended—

19 (i) in subparagraph (B)(ii), by strik-
 20 ing “during the 2-year period beginning on
 21 the date the affidavit is signed” and insert-
 22 ing “during the applicable 2-year period
 23 (as defined in subparagraph (D))”;

24 (ii) in subparagraph (C), by striking
 25 “during the 2-year period described in sub-

1 paragraph (B)(ii)” and inserting “during
2 the applicable 2-year period”; and

3 (iii) by adding at the end the fol-
4 lowing new subparagraph:

5 “(D) APPLICABLE 2-YEAR PERIODS FOR
6 EFFECTIVENESS OF AFFIDAVITS.—In this sub-
7 section, the term ‘applicable 2-year period’
8 means, with respect to an affidavit of a physi-
9 cian or practitioner under subparagraph (B),
10 the 2-year period beginning on the date the af-
11 fidavit is signed and includes each subsequent
12 2-year period unless the physician or practi-
13 tioner involved provides notice to the Secretary
14 (in a form and manner specified by the Sec-
15 retary), not later than 30 days before the end
16 of the previous 2-year period, that the physician
17 or practitioner does not want to extend the ap-
18 plication of the affidavit for such subsequent 2-
19 year period.”.

20 (B) EFFECTIVE DATE.—The amendments
21 made by subparagraph (A) shall apply to affi-
22 davits entered into on or after the date that is
23 60 days after the date of the enactment of this
24 Act.

1 (2) PUBLIC AVAILABILITY OF INFORMATION ON
2 OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section
3 1802(b) of the Social Security Act (42 U.S.C.
4 1395a(b)) is amended—

5 (A) in paragraph (5), by adding at the end
6 the following new subparagraph:

7 “(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—
8 The term ‘opt-out physician or practitioner’ means
9 a physician or practitioner who has in effect an affi-
10 davit under paragraph (3)(B).”;

11 (B) by redesignating paragraph (5) as
12 paragraph (6); and

13 (C) by inserting after paragraph (4) the
14 following new paragraph:

15 “(5) POSTING OF INFORMATION ON OPT-OUT
16 PHYSICIANS AND PRACTITIONERS.—

17 “(A) IN GENERAL.—Beginning not later
18 than February 1, 2015, the Secretary shall
19 make publicly available through an appropriate
20 publicly accessible website of the Department of
21 Health and Human Services information on the
22 number and characteristics of opt-out physi-
23 cians and practitioners and shall update such
24 information on such website not less often than
25 annually.

1 “(B) INFORMATION TO BE INCLUDED.—

2 The information to be made available under
3 subparagraph (A) shall include at least the fol-
4 lowing with respect to opt-out physicians and
5 practitioners:

6 “(i) Their number.

7 “(ii) Their physician or professional
8 specialty or other designation.

9 “(iii) Their geographic distribution.

10 “(iv) The timing of their becoming
11 opt-out physicians and practitioners, rel-
12 ative to when they first entered practice
13 and with respect to applicable 2-year peri-
14 ods.

15 “(v) The proportion of such physi-
16 cians and practitioners who billed for
17 emergency or urgent care services.”.

18 (b) GAINSHARING STUDY AND REPORT.—Not later
19 than 6 months after the date of the enactment of this Act,
20 the Secretary of Health and Human Services, in consulta-
21 tion with the Inspector General of the Department of
22 Health and Human Services, shall submit to Congress a
23 report with legislative recommendations to amend existing
24 fraud and abuse laws, through exceptions, safe harbors,
25 or other narrowly targeted provisions, to permit

1 gainsharing or similar arrangements between physicians
2 and hospitals that improve care while reducing waste and
3 increasing efficiency. The report shall—

4 (1) consider whether such provisions should
5 apply to ownership interests, compensation arrange-
6 ments, or other relationships;

7 (2) describe how the recommendations address
8 accountability, transparency, and quality, including
9 how best to limit inducements to stint on care, dis-
10 charge patients prematurely, or otherwise reduce or
11 limit medically necessary care; and

12 (3) consider whether a portion of any savings
13 generated by such arrangements should accrue to
14 the Medicare program under title XVIII of the So-
15 cial Security Act.

16 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC
17 HEALTH RECORD SYSTEMS.—

18 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-
19 SPREAD EHR INTEROPERABILITY.—

20 (A) OBJECTIVE.—As a consequence of a
21 significant Federal investment in the implemen-
22 tation of health information technology through
23 the Medicare and Medicaid EHR incentive pro-
24 grams, Congress declares it a national objective
25 to achieve widespread exchange of health infor-

1 mation through interoperable certified EHR
2 technology nationwide by December 31, 2017.

3 (B) DEFINITIONS.—In this paragraph:

4 (i) WIDESPREAD INTEROPER-
5 ABILITY.—The term “widespread inter-
6 operability” means interoperability between
7 certified EHR technology systems em-
8 ployed by meaningful EHR users under
9 the Medicare and Medicaid EHR incentive
10 programs and other clinicians and health
11 care providers on a nationwide basis.

12 (ii) INTEROPERABILITY.—The term
13 “interoperability” means the ability of two
14 or more health information systems or
15 components to exchange clinical and other
16 information and to use the information
17 that has been exchanged using common
18 standards as to provide access to longitu-
19 dinal information for health care providers
20 in order to facilitate coordinated care and
21 improved patient outcomes.

22 (C) ESTABLISHMENT OF METRICS.—Not
23 later than July 1, 2015, and in consultation
24 with stakeholders, the Secretary shall establish
25 metrics to be used to determine if and to the

1 extent that the objective described in subpara-
2 graph (A) has been achieved.

3 (D) RECOMMENDATIONS IF OBJECTIVE
4 NOT ACHIEVED.—If the Secretary of Health
5 and Human Services determines that the objec-
6 tive described in subparagraph (A) has not been
7 achieved by December 31, 2017, then the Sec-
8 retary shall submit to Congress a report, by not
9 later than December 31, 2018, that identifies
10 barriers to such objective and recommends ac-
11 tions that the Federal Government can take to
12 achieve such objective. Such recommended ac-
13 tions may include recommendations—

14 (i) to adjust payments for not being
15 meaningful EHR users under the Medicare
16 EHR incentive programs; and

17 (ii) for criteria for decertifying cer-
18 tified EHR technology products.

19 (2) PREVENTING BLOCKING THE SHARING OF
20 INFORMATION.—

21 (A) FOR MEANINGFUL EHR PROFES-
22 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-
23 cial Security Act (42 U.S.C. 1395w-
24 4(o)(2)(A)(ii)) is amended by inserting before
25 the period at the end the following: “, and the

1 professional demonstrates (through a process
2 specified by the Secretary, such as the use of an
3 attestation) that the professional has not know-
4 ingly and willfully taken any action to limit or
5 restrict the compatibility or interoperability of
6 the certified EHR technology”.

7 (B) FOR MEANINGFUL EHR HOSPITALS.—
8 Section 1886(n)(3)(A)(ii) of the Social Security
9 Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amend-
10 ed by inserting before the period at the end the
11 following: “, and the hospital demonstrates
12 (through a process specified by the Secretary,
13 such as the use of an attestation) that the hos-
14 pital has not knowingly and willfully taken any
15 action to limit or restrict the compatibility or
16 interoperability of the certified EHR tech-
17 nology”.

18 (C) EFFECTIVE DATE.—The amendments
19 made by this subsection shall apply to meaning-
20 ful EHR users as of the date that is one year
21 after the date of the enactment of this Act.

22 (3) STUDY AND REPORT ON THE FEASIBILITY
23 OF ESTABLISHING A WEBSITE TO COMPARE CER-
24 TIFIED EHR TECHNOLOGY PRODUCTS.—

1 (A) STUDY.—The Secretary shall conduct
2 a study to examine the feasibility of estab-
3 lishing mechanisms that includes aggregated re-
4 sults of surveys of meaningful EHR users on
5 the functionality of certified EHR technology
6 products to enable such users to directly com-
7 pare the functionality and other features of
8 such products. Such information may be made
9 available through contracts with physician, hos-
10 pital, or other organizations that maintain such
11 comparative information.

12 (B) REPORT.—Not later than 1 year after
13 the date of the enactment of this Act, the Sec-
14 retary shall submit to Congress a report on the
15 website. The report shall include information on
16 the benefits of, and resources needed to develop
17 and maintain, such a website.

18 (4) DEFINITIONS.—In this subsection:

19 (A) The term “certified EHR technology”
20 has the meaning given such term in section
21 1848(o)(4) of the Social Security Act (42
22 U.S.C. 1395w–4(o)(4)).

23 (B) The term “meaningful EHR user” has
24 the meaning given such term under the Medi-
25 care EHR incentive programs.

1 (C) The term “Medicare and Medicaid
2 EHR incentive programs” means—

3 (i) in the case of the Medicare pro-
4 gram under title XVIII of the Social Secu-
5 rity Act, the incentive programs under sec-
6 tion 1814(l)(3), section 1848(o), sub-
7 sections (l) and (m) of section 1853, and
8 section 1886(n) of the Social Security Act
9 (42 U.S.C. 1395f(l)(3), 1395w-4(o),
10 1395w-23, 1395ww(n)); and

11 (ii) in the case of the Medicaid pro-
12 gram under title XIX of such Act, the in-
13 centive program under subsections
14 (a)(3)(F) and (t) of section 1903 of such
15 Act (42 U.S.C. 1396b).

16 (D) The term “Secretary” means the Sec-
17 retary of Health and Human Services.

18 (d) GAO STUDIES AND REPORTS ON THE USE OF
19 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-
20 MOTE PATIENT MONITORING SERVICES.—

21 (1) STUDY ON TELEHEALTH SERVICES.—The
22 Comptroller General of the United States shall con-
23 duct a study on the following:

24 (A) How the definition of telehealth across
25 various Federal programs and Federal efforts

1 can inform the use of telehealth in the Medicare
2 program under title XVIII of the Social Secu-
3 rity Act (42 U.S.C. 1395 et seq.).

4 (B) Issues that can facilitate or inhibit the
5 use of telehealth under the Medicare program
6 under such title, including oversight and profes-
7 sional licensure, changing technology, privacy
8 and security, infrastructure requirements, and
9 varying needs across urban and rural areas.

10 (C) Potential implications of greater use of
11 telehealth with respect to payment and delivery
12 system transformations under the Medicare
13 program under such title XVIII and the Med-
14 icaid program under title XIX of such Act (42
15 U.S.C. 1396 et seq.).

16 (D) How the Centers for Medicare & Med-
17 icaid Services conducts oversight of payments
18 made under the Medicare program under such
19 title XVIII to providers for telehealth services.

20 (2) STUDY ON REMOTE PATIENT MONITORING
21 SERVICES.—

22 (A) IN GENERAL.—The Comptroller Gen-
23 eral of the United States shall conduct a
24 study—

1 (i) of the dissemination of remote pa-
2 tient monitoring technology in the private
3 health insurance market;

4 (ii) of the financial incentives in the
5 private health insurance market relating to
6 adoption of such technology;

7 (iii) of the barriers to adoption of
8 such services under the Medicare program
9 under title XVIII of the Social Security
10 Act;

11 (iv) that evaluates the patients, condi-
12 tions, and clinical circumstances that could
13 most benefit from remote patient moni-
14 toring services; and

15 (v) that evaluates the challenges re-
16 lated to establishing appropriate valuation
17 for remote patient monitoring services
18 under the Medicare physician fee schedule
19 under section 1848 of the Social Security
20 Act (42 U.S.C. 1395w-4) in order to accu-
21 rately reflect the resources involved in fur-
22 nishing such services.

23 (B) DEFINITIONS.—For purposes of this
24 paragraph:

1 (i) REMOTE PATIENT MONITORING
2 SERVICES.—The term “remote patient
3 monitoring services” means services fur-
4 nished through remote patient monitoring
5 technology.

6 (ii) REMOTE PATIENT MONITORING
7 TECHNOLOGY.—The term “remote patient
8 monitoring technology” means a coordi-
9 nated system that uses one or more home-
10 based or mobile monitoring devices that
11 automatically transmit vital sign data or
12 information on activities of daily living and
13 may include responses to assessment ques-
14 tions collected on the devices wirelessly or
15 through a telecommunications connection
16 to a server that complies with the Federal
17 regulations (concerning the privacy of indi-
18 vidually identifiable health information)
19 promulgated under section 264(c) of the
20 Health Insurance Portability and Account-
21 ability Act of 1996, as part of an estab-
22 lished plan of care for that patient that in-
23 cludes the review and interpretation of that
24 data by a health care professional.

1 (3) REPORTS.—Not later than 24 months after
2 the date of the enactment of this Act, the Comp-
3 troller General shall submit to Congress—

4 (A) a report containing the results of the
5 study conducted under paragraph (1); and

6 (B) a report containing the results of the
7 study conducted under paragraph (2).

8 A report required under this paragraph shall be sub-
9 mitted together with recommendations for such leg-
10 islation and administrative action as the Comptroller
11 General determines appropriate. The Comptroller
12 General may submit one report containing the re-
13 sults described in subparagraphs (A) and (B) and
14 the recommendations described in the previous sen-
15 tence.

16 (e) RULE OF CONSTRUCTION REGARDING
17 HEALTHCARE PROVIDER STANDARDS OF CARE.—

18 (1) MAINTENANCE OF STATE STANDARDS.—

19 The development, recognition, or implementation of
20 any guideline or other standard under any Federal
21 health care provision shall not be construed—

22 (A) to establish the standard of care or
23 duty of care owed by a health care provider to
24 a patient in any medical malpractice or medical
25 product liability action or claim; or

1 (B) to preempt any standard of care or
2 duty of care, owed by a health care provider to
3 a patient, duly established under State or com-
4 mon law.

5 (2) DEFINITIONS.—For purposes of this sub-
6 section:

7 (A) FEDERAL HEALTH CARE PROVISION.—
8 The term “Federal health care provision”
9 means any provision of the Patient Protection
10 and Affordable Care Act (Public Law 111–
11 148), title I or subtitle B of title II of the
12 Health Care and Education Reconciliation Act
13 of 2010 (Public Law 111–152), or title XVIII
14 or XIX of the Social Security Act.

15 (B) HEALTH CARE PROVIDER.—The term
16 “health care provider” means any individual or
17 entity—

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

21 (ii) required to be so licensed, reg-
22 istered, or certified but that is exempted
23 by other statute or regulation.

24 (C) MEDICAL MALPRACTICE OR MEDICAL
25 PRODUCT LIABILITY ACTION OR CLAIM.—The

1 term “medical malpractice or medical product
2 liability action or claim” means a medical mal-
3 practice action or claim (as defined in section
4 431(7) of the Health Care Quality Improve-
5 ment Act of 1986 (42 U.S.C. 11151(7))) and
6 includes a liability action or claim relating to a
7 health care provider’s prescription or provision
8 of a drug, device, or biological product (as such
9 terms are defined in section 201 of the Federal
10 Food, Drug, and Cosmetic Act or section 351
11 of the Public Health Service Act).

12 (D) STATE.—The term “State” includes
13 the District of Columbia, Puerto Rico, and any
14 other commonwealth, possession, or territory of
15 the United States.

16 (3) PRESERVATION OF STATE LAW.—No provi-
17 sion of the Patient Protection and Affordable Care
18 Act (Public Law 111–148), title I or subtitle B of
19 title II of the Health Care and Education Reconcili-
20 ation Act of 2010 (Public Law 111–152), or title
21 XVIII or XIX of the Social Security Act shall be
22 construed to preempt any State or common law gov-
23 erning medical professional or medical product liabil-
24 ity actions or claims.

1 **SEC. 10. SAVINGS FROM OVERSEAS CONTINGENCY AND RE-**
2 **LATED ACTIVITIES.**

3 (a) IN GENERAL.—Section 251 of the Balanced
4 Budget and Emergency Deficit Control Act of 1985 (2
5 U.S.C. 901) is amended—

6 (1) in subsection (b)(2)(A)(ii), by inserting “for
7 fiscal years 2012 through 2015,” before “the Con-
8 gress”; and

9 (2) by adding at the end the following:

10 “(E) OVERSEAS CONTINGENCY OPER-
11 ATIONS/GLOBAL WAR ON TERRORISM.—If, for
12 fiscal years 2016 through 2021, appropriations
13 for discretionary accounts are enacted that
14 Congress designates for Overseas Contingency
15 Operations/Global War on Terrorism in statute
16 on an account by account basis and the Presi-
17 dent subsequently so designates, the adjustment
18 for the fiscal year shall be the total of such ap-
19 propriations for the fiscal year in discretionary
20 accounts designated as being for Overseas Con-
21 tingency Operations/Global War on Terrorism,
22 but not to exceed—

23 “(i) For fiscal year 2016,
24 \$29,946,000,000 in budget authority.

25 “(ii) For fiscal year 2017,
26 \$29,946,000,000 in budget authority.

1 “(iii) For fiscal year 2018,
2 \$29,946,000,000 in budget authority.

3 “(iv) For fiscal year 2019,
4 \$29,946,000,000 in budget authority.

5 “(v) For fiscal year 2020,
6 \$29,946,000,000 in budget authority.

7 “(vi) For fiscal year 2021,
8 \$29,946,000,000 in budget authority.”.

9 (b) BREACH.—Section 251(a)(2) of such Act (2
10 U.S.C. 901(a)(2)) is amended to read as follows:

11 “(2) ELIMINATING A BREACH.—

12 “(A) IN GENERAL.—Each non-exempt ac-
13 count within a category shall be reduced by a
14 dollar amount calculated by multiplying the en-
15 acted level of sequestrable budgetary resources
16 in that account by the uniform percentage nec-
17 essary to eliminate a breach within that cat-
18 egory.

19 “(B) OVERSEAS CONTINGENCIES.—Any
20 amount of budget authority for Overseas Con-
21 tingency Operations/Global War on Terrorism
22 for fiscal years 2016 through 2021 in excess of
23 the levels set in subsection 251(b)(2)(E) shall
24 be counted in determining whether a breach has
25 occurred in the security category and the non-

1 security category on a proportional basis to the
2 total spending for overseas contingency oper-
3 ations in the security category and the nonsecu-
4 rity category.”.

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