

**[Discussion Draft]**

113TH CONGRESS  
1ST SESSION

**H. R.** \_\_\_\_\_

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

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IN THE HOUSE OF REPRESENTATIVES

Mr. BURGESS (for himself, Mr. PALLONE, Mr. UPTON, Mr. WAXMAN, Mr. PITTS, and Mr. DINGELL) introduced the following bill; which was referred to the Committee on \_\_\_\_\_

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**A BILL**

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

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 “\_\_\_\_\_ Act of 2013”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Reform of sustainable growth rate (SGR) and Medicare payment for physicians' services.
- Sec. 3. Expanding availability of Medicare data.
- Sec. 4. Encouraging care coordination and medical homes.
- Sec. 5. Miscellaneous.

1 **SECTION 2. REFORM OF SUSTAINABLE GROWTH RATE**  
2 **(SGR) AND MEDICARE PAYMENT FOR PHYSI-**  
3 **CIANs' SERVICES.**

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

5 (1) REPEAL OF SGR PAYMENT METHOD-  
6 OLOGY.—Section 1848 of the Social Security Act  
7 (42 U.S.C. 1395w-4) is amended—

8 (A) in subsection (d)—

9 (i) in paragraph (1)(A), by inserting  
10 “or a subsequent paragraph or section  
11 1848A” after “paragraph (4)”; and

12 (ii) in paragraph (4)—

13 (I) in the heading, by striking  
14 “YEARS BEGINNING WITH 2001” and  
15 inserting “2001, 2002, AND 2003”; and

16 (II) in subparagraph (A), by  
17 striking “a year beginning with 2001”  
18 and inserting “2001, 2002, and  
19 2003”; and

20 (B) in subsection (f)—

1 (i) in paragraph (1)(B), by inserting  
2 “through 2013” after “of such succeeding  
3 year”; and

4 (ii) in paragraph (2), by inserting  
5 “and ending with 2013” after “beginning  
6 with 2000”.

7 (2) UPDATE OF RATES FOR 2014 THROUGH  
8 2018.—Subsection (d) of section 1848 of the Social  
9 Security Act (42 U.S.C. 1395w–4) is amended by  
10 adding at the end the following new paragraph:

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

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

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

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

21 “(16) UPDATE BEGINNING WITH 2019.—

22 “(A) IN GENERAL.—Subject to subpara-  
23 graph (B), the update to the single conversion  
24 factor established in paragraph (1)(C) for each  
25 year beginning with 2019 shall be 0.5 percent.

1                   “(B) ADJUSTMENT.—In the case of an eli-  
2                   gible professional (as defined in subsection  
3                   (k)(3)) who does not have a payment arrange-  
4                   ment described in section 1848A(a) in effect,  
5                   the update under subparagraph (A) for a year  
6                   beginning with 2019 shall be adjusted by the  
7                   applicable quality adjustment determined under  
8                   subsection (q)(3) for the year involved.”; and

9                   (B) in subsection (i)(1)—

10                   (i) by striking “and” at the end of  
11                   subparagraph (D);

12                   (ii) by striking the period at the end  
13                   of subparagraph (E) and inserting “,  
14                   and”; and

15                   (iii) by adding at the end the fol-  
16                   lowing new subparagraph:

17                   “(F) the implementation of subsection  
18                   (q).”.

19                   (2) ENHANCING PHYSICIAN QUALITY REPORT-  
20                   ING SYSTEM TO SUPPORT QUALITY UPDATE INCEN-  
21                   TIVE PROGRAM.—Section 1848 of the Social Secu-  
22                   rity Act (42 U.S.C. 1395w-4) is amended—

23                   (A) in subsection (k)(1), in the first sen-  
24                   tence, by inserting “and, if applicable, clinical

1 practice improvement activities,” after “quality  
2 measures”;

3 (B) in subsection (k)(2)—

4 (i) in subparagraph (C)—

5 (I) in the subparagraph heading,  
6 by striking “AND SUBSEQUENT  
7 YEARS” and inserting “THROUGH  
8 2018”; and

9 (II) in clause (i), by inserting  
10 “(before 2019)” after “subsequent  
11 year”;

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

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

16 “(D) FOR 2019 AND SUBSEQUENT  
17 YEARS.—For purposes of reporting data on  
18 quality measures and, as applicable clinical  
19 practice improvement activities, for covered pro-  
20 fessional services furnished during 2019 and  
21 each subsequent year, subject to subsection  
22 (q)(1)(D), the quality measures (including elec-  
23 tronic prescribing quality measures) and clinical  
24 practice improvement activities specified under  
25 this paragraph shall be, with respect to an eligi-

1           ble professional, the quality measures and, as  
2           applicable, clinical practice improvement activi-  
3           ties within the final quality measure set under  
4           paragraph (9)(F) applicable to the peer cohort  
5           of such provider.”; and

6                   (iv) in subparagraph (E), as redesign-  
7                   nated by subparagraph (B)(ii) of this para-  
8                   graph, by striking “AND SUBSEQUENT  
9                   YEARS”;

10           (C) in subsection (k)(3)—

11                   (i) in the paragraph heading, by strik-  
12                   ing “COVERED PROFESSIONAL SERVICES  
13                   AND ELIGIBLE PROFESSIONALS DEFINED”  
14                   and inserting “DEFINITIONS”; and

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

17                   “(C) CLINICAL PRACTICE IMPROVEMENT  
18                   ACTIVITIES.—The term ‘clinical practice im-  
19                   provement activity’ means an activity that rel-  
20                   evant eligible professional organizations and  
21                   other relevant stakeholders identify as improv-  
22                   ing clinical practice or care delivery and that  
23                   the Secretary determines, when effectively exe-  
24                   cuted, is likely to result in improved outcomes.

1           “(D) ELIGIBLE PROFESSIONAL ORGANIZA-  
2           TION.—The term ‘eligible professional organiza-  
3           tion’ means a professional organization that is  
4           recognized by the American Board of Medical  
5           Specialties, American Osteopathic Association,  
6           American Board of Physician Specialties, or an  
7           equivalent certification board.

8           “(E) PEER COHORT.—The term ‘peer co-  
9           hort’ means a peer cohort identified on the list  
10          under paragraph (9)(B), as updated under  
11          clause (ii) of such paragraph.”;

12          (D) in subsection (k)(7), by striking “ and  
13          the application of paragraphs (4) and (5)” and  
14          inserting “, the application of paragraphs (4)  
15          and (5), and the implementation of paragraph  
16          (9)”;

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

19          “(9) ESTABLISHMENT OF QUALITY MEASURE  
20          SETS.—

21          “(A) IN GENERAL.—Under the system  
22          under this subsection—

23                  “(i) for each peer cohort identified  
24                  under subparagraph (B) and in accordance  
25                  with this paragraph, there shall be pub-

1                   lished a final quality measure set under  
2                   subparagraph (F), which shall consist of  
3                   quality measures and may also consist of  
4                   clinical practice improvement activities,  
5                   with respect to which eligible professionals  
6                   shall, subject to subsection (m)(3)(C), be  
7                   assessed for purposes of determining, for  
8                   years beginning with 2019, the quality ad-  
9                   justment under subsection (q)(3) applica-  
10                  ble to such professionals; and

11                  “(ii) each eligible professional shall  
12                  self-identify, in accordance with subpara-  
13                  graph (B), within such a peer cohort for  
14                  purposes of such assessments.

15                  “(B) PEER COHORTS.—The Secretary  
16                  shall identify (and publish a list of) peer co-  
17                  horts by which eligible professionals shall self-  
18                  identify for purposes of this subsection and sub-  
19                  section (q) with respect to a performance period  
20                  (as defined in subsection (q)(2)(B)) for a year  
21                  beginning with 2019. There shall be included as  
22                  a peer cohort a peer cohort developed by the  
23                  Secretary for multispecialty groups. Such self-  
24                  identification will be made through such a proc-

1           ess and at such time as specified under the sys-  
2           tem under this subsection. Such list—

3                   “(i) shall include, as peer cohorts,  
4                   provider specialties defined by the Amer-  
5                   ican Board of Medical Specialties or equiv-  
6                   alent certification boards and such other  
7                   cohorts as established under this section in  
8                   order to capture classifications of providers  
9                   across eligible professional organizations  
10                  and other practice areas, groupings, or cat-  
11                  egories; and

12                   “(ii) shall be updated from time to  
13                  time.

14                  “(C) QUALITY MEASURES FOR MEASURE  
15                  SETS.—

16                   “(i) DEVELOPMENT.—Under the sys-  
17                   tem under this subsection there shall be es-  
18                   tablished a process for the development of  
19                   quality measures under this subparagraph  
20                   for purposes of potential inclusion of such  
21                   measures in measure sets under this para-  
22                   graph. Under such process—

23                           “(I) there shall be coordination,  
24                           to the extent possible, across organi-  
25                           zations developing such measures;

1 “(II) eligible professional organi-  
2 zations and other relevant stake-  
3 holders may submit best practices and  
4 clinical practice guidelines for the de-  
5 velopment of quality measures that  
6 address quality domains (as defined  
7 under clause (ii)) for potential inclu-  
8 sion in such measure sets;

9 “(III) there is encouraged to be  
10 developed, as appropriate, meaningful  
11 outcome measures (or quality of life  
12 measures in cases for which outcomes  
13 may not be a valid measurement),  
14 process measures, and patient experi-  
15 ence measures; and

16 “(IV) measures developed under  
17 this clause shall be developed, to the  
18 extent possible, in accordance with  
19 best clinical practices.

20 “(ii) QUALITY DOMAINS.—For pur-  
21 poses of this paragraph, the term ‘quality  
22 domains’ means at least the following do-  
23 mains:

24 “(I) Clinical care.

25 “(II) Safety.

1 “(III) Care coordination.

2 “(IV) Patient and caregiver expe-  
3 rience.

4 “(V) Population health and pre-  
5 vention.

6 “(D) PROCESS FOR ESTABLISHING QUAL-  
7 ITY MEASURE SETS.—

8 “(i) IN GENERAL.—Under the system  
9 under this subsection, for purposes of sub-  
10 paragraph (A), there shall be established a  
11 process to approve final quality measure  
12 sets under this paragraph for peer cohorts.  
13 Each such final quality measure set shall  
14 be composed of quality measures (and, as  
15 applicable, clinical practice improvement  
16 activities) with respect to which eligible  
17 professionals within such peer cohort shall  
18 report under this subsection and be as-  
19 sessed under subsection (q). Such process  
20 shall provide—

21 “(I) for the establishment of cri-  
22 teria, which shall be made publicly  
23 available before the request is made  
24 under clause (ii), for selecting such  
25 measures and activities for potential

1 inclusion in such a final quality meas-  
2 ure set; and

3 “(II) that all quality domains  
4 and peer cohorts are addressed by  
5 measures selected to be included in a  
6 measures set under this subpara-  
7 graph, which may include through the  
8 use of such a measure that addresses  
9 more than one such domain or cohort.

10 “(ii) SOLICITATION OF PUBLIC INPUT  
11 ON QUALITY MEASURES AND CLINICAL  
12 PRACTICE IMPROVEMENT ACTIVITIES.—  
13 Under the process established under clause  
14 (i), eligible professional organizations and  
15 other relevant stakeholders shall be author-  
16 ized to identify and submit quality meas-  
17 ures and clinical practice improvement ac-  
18 tivities (as defined in paragraph (3)(C))  
19 for selection under this paragraph. For  
20 purposes of the previous sentence, meas-  
21 ures and activities may be submitted re-  
22 gardless of whether such measures were  
23 previously published in a proposed rule or  
24 approved by an entity with a contract  
25 under section 1890(a).

1 “(E) CORE MEASURE SETS.—

2 “(i) IN GENERAL.—Under the process  
3 established under subparagraph (D)(i), the  
4 Secretary—

5 “(I) shall select, from quality  
6 measures described in clause (ii) ap-  
7 plicable to a peer cohort, quality  
8 measures to be included in a core  
9 measure set for such cohort;

10 “(II) shall, to the extent there  
11 are insufficient quality measures ap-  
12 plicable to a peer cohort to address  
13 one or more applicable quality do-  
14 mains, select to be included in a core  
15 measure set for such cohort such clin-  
16 ical practice improvement activities  
17 described in clause (ii)(IV) as is need-  
18 ed and available to sufficiently ad-  
19 dress such an applicable domain with  
20 respect to such peer cohort; and

21 “(III) may select, to the extent  
22 determined appropriate, any addi-  
23 tional clinical practice improvement  
24 activities described in clause (ii)(IV)  
25 applicable to a peer cohort to be in-

1 included in a core measure set for such  
2 cohort.

3 Activities selected under this paragraph  
4 shall be selected with consideration of best  
5 clinical practices.

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

13 “(I) a measure endorsed by a  
14 consensus-based entity;

15 “(II) a measure developed under  
16 paragraph (2)(C) or a measure other-  
17 wise applied or developed for a similar  
18 purpose under this section;

19 “(III) a measure developed under  
20 subparagraph (C); or

21 “(IV) a measure or activity sub-  
22 mitted under subparagraph (D)(ii).

23 A measure or activity may be selected  
24 under this subparagraph, regardless of  
25 whether such measure or activity was pre-

1 viously published in a proposed rule. A  
2 measure so selected shall be evidence-based  
3 but (other than a measure described in  
4 subclause (I)) shall not be required to be  
5 consensus-based.

6 “(iii) TRANSPARENCY.—Before a core  
7 measure set under clause (i) may be pub-  
8 lished as a final quality measure set under  
9 subparagraph (F), there shall be made  
10 available for public comment, and sub-  
11 mitted for publication in specialty-appro-  
12 priate peer-reviewed journals, each applica-  
13 ble core measure set under clause (i) and  
14 the method for developing and selecting  
15 measures, including clinical and other data  
16 supporting such measures, and, as applica-  
17 ble, selecting clinical practice improvement  
18 activities included within such set.

19 “(F) FINAL MEASURE SETS.—Not later  
20 than November 15 of the year prior to the first  
21 day of a performance period and taking into ac-  
22 count public comment received pursuant to sub-  
23 paragraph (E)(iii), the Secretary shall through  
24 rulemaking publish a final quality measure set

1 for each peer cohort to be applied for such per-  
2 formance period.

3 “(G) PERIODIC REVIEW AND UPDATES.—

4 “(i) IN GENERAL.—In carrying out  
5 this paragraph, under the system under  
6 this subsection, there shall periodically be  
7 reviewed—

8 “(I) the quality measures and  
9 clinical practice improvement activities  
10 selected for inclusion in final quality  
11 measure sets under this paragraph for  
12 each year such measures and activi-  
13 ties are to be applied under this sub-  
14 section or subsection (q) to ensure  
15 that such measures and activities con-  
16 tinue to meet the conditions applicable  
17 to such measures and activities for  
18 such selection; and

19 “(II) the final quality measures  
20 sets published under subparagraph  
21 (F) for each year such sets are to be  
22 applied to peer cohorts of eligible pro-  
23 fessionals to ensure that each applica-  
24 ble set continues to meet the condi-

1                   tions applicable to such sets before  
2                   being so published.

3                   “(ii) COLLABORATION WITH STAKE-  
4                   HOLDERS.—In carrying out clause (i), eli-  
5                   gible professional organizations and other  
6                   relevant stakeholders may identify and  
7                   submit updates to quality measures and  
8                   clinical practice improvement activities se-  
9                   lected under this paragraph for inclusion  
10                  in final quality measures sets as well as  
11                  any additional quality measures and clin-  
12                  ical practice improvement activities. Not  
13                  later than November 15 of the year prior  
14                  to the first day of a performance period,  
15                  submissions under this clause shall be re-  
16                  viewed.

17                  “(iii) ADDITIONAL, AND UPDATES TO,  
18                  MEASURES AND ACTIVITIES.—Based on  
19                  the review conducted under this subpara-  
20                  graph for a period, as needed, there shall  
21                  be—

22                  “(I) selected additional, and up-  
23                  dates to, quality measures and clinical  
24                  practice improvement activities se-  
25                  lected under this paragraph for poten-

1            tial inclusion in final quality measure  
2            sets in the same manner such quality  
3            measures and clinical practice im-  
4            provement activities are selected  
5            under this paragraph for such poten-  
6            tial inclusion; and

7                       “(II) modified final quality meas-  
8            ure sets published under subpara-  
9            graph (F) in the same manner as  
10           such sets are approved under such  
11           subparagraph.

12           For purposes of this subsection and sub-  
13           section (q), a final quality measure set, as  
14           modified under this subparagraph, shall be  
15           treated in the same manner as a final  
16           quality measure set published under sub-  
17           paragraph (F).

18                      “(iv) TRANSPARENCY.—

19                                 “(I) NOTIFICATION REQUIRED  
20           FOR CERTAIN MODIFICATIONS.—In  
21           the case of a modification under  
22           clause (iii)(II) that adds, materially  
23           changes, or removes a measure or ac-  
24           tivity from a measure set, such modi-  
25           fication shall not apply under this

1 subsection or subsection (q) unless no-  
2 tification of such modification is made  
3 available to applicable eligible profes-  
4 sionals.

5 “(II) PUBLIC AVAILABILITY OF  
6 MODIFIED MEASURE SETS.—Subpara-  
7 graph (E)(iii) shall apply with respect  
8 measure sets modified under clause  
9 (iii)(II) in the same manner as such  
10 subparagraph applies to applicable  
11 core measure sets under subparagraph  
12 (E).

13 “(H) COORDINATION WITH EXISTING PRO-  
14 GRAMS.—The development and selection of  
15 quality measures and clinical practice improve-  
16 ment activities under this paragraph shall, as  
17 appropriate, be coordinated with the develop-  
18 ment and selection of existing measures and re-  
19 quirements, such as the development of the  
20 Physician Compare Website under subsection  
21 (m)(5)(G) and the application of resource use  
22 management under subsection (n)(9). To the  
23 extent feasible, such measures and activities  
24 shall align with measures used by other payers  
25 and with measures and activities in use under

1 other programs in order to streamline the proc-  
2 ess of such development and selection under  
3 this paragraph. The Secretary shall develop a  
4 plan to integrate reporting on quality measures  
5 under this subsection with reporting require-  
6 ments under subsection (o) relating to the  
7 meaningful use of certified EHR technology.

8 “(I) CONSULTATION WITH ELIGIBLE PRO-  
9 FESSIONAL ORGANIZATIONS AND OTHER REL-  
10 EVANT STAKEHOLDERS.—Eligible professional  
11 organizations (as defined in paragraph (3)(D))  
12 and other relevant stakeholders, including State  
13 medical societies, shall be consulted in carrying  
14 out this paragraph.

15 “(J) OPTIONAL APPLICATION.—The proc-  
16 ess under section 1890A is not required to  
17 apply to the development or selection of meas-  
18 ures under this paragraph.”; and

19 (F) in subsection (m)(3)(C)(i), by adding  
20 at the end the following new sentence: “Such  
21 process shall, beginning for 2019, treat eligible  
22 professionals in such a group practice as report-  
23 ing on measures for purposes of application of  
24 subsections (q) and (a)(8)(A)(iii) if, in lieu of  
25 reporting measures under subsection (k)(2)(D),

1 the group practice reports measures determined  
2 appropriate by the Secretary.”.

3 (3) ESTABLISHMENT OF QUALITY UPDATE IN-  
4 CENTIVE PROGRAM.—

5 (A) IN GENERAL.—Section 1848 of the So-  
6 cial Security Act (42 U.S.C. 1395w-4) is  
7 amended by adding at the end the following  
8 new subsection:

9 “(q) QUALITY UPDATE INCENTIVE PROGRAM.—

10 “(1) ESTABLISHMENT.—

11 “(A) IN GENERAL.—The Secretary shall  
12 establish an eligible professional quality update  
13 incentive program (in this section referred to as  
14 the ‘update incentive program’) under which—

15 “(i) there is developed and applied, in  
16 accordance with paragraph (2), appro-  
17 priate methodologies for assessing the per-  
18 formance of eligible professionals with re-  
19 spect to quality measures and clinical prac-  
20 tice improvement activities included within  
21 the final quality measure sets published  
22 under subsection (k)(9)(F) applicable to  
23 the peer cohorts of such providers;

24 “(ii) there is applied, consistent with  
25 the system under subsection (k), methods

1 for collecting information needed for such  
2 assessments (which shall involve the min-  
3 imum amount of administrative burden re-  
4 quired to ensure reliable results); and

5 “(iii) the applicable update adjust-  
6 ments under paragraph (3) are determined  
7 by such assessments.

8 “(B) DEFINITIONS.—

9 “(i) ELIGIBLE PROFESSIONAL.—In  
10 this subsection, the term ‘eligible profes-  
11 sional’ has the meaning given such term in  
12 subsection (k)(3), except that such term  
13 shall not include a professional who has a  
14 payment arrangement described in section  
15 1848A(a)(1) in effect.

16 “(ii) PEER COHORTS; CLINICAL PRAC-  
17 TICE IMPROVEMENT ACTIVITIES; ELIGIBLE  
18 PROFESSIONAL ORGANIZATIONS.—In this  
19 subsection, the terms ‘peer cohort’, ‘clinical  
20 practice improvement activity’, and ‘eligible  
21 professional organization’ have the mean-  
22 ings given such terms in subsection (k)(3).

23 “(C) CONSULTATION WITH ELIGIBLE PRO-  
24 FESSIONAL ORGANIZATIONS AND OTHER REL-  
25 EVANT STAKEHOLDERS.—Eligible professional

1 organizations and other relevant stakeholders,  
2 including State medical societies, shall be con-  
3 sulted in carrying out this subsection.

4 “(D) APPLICATION AT GROUP PRACTICE  
5 LEVEL.—The Secretary shall establish a proc-  
6 ess, consistent with subsection (m)(3)(C), under  
7 which the provisions of this subsection are ap-  
8 plied to eligible professionals in a group prac-  
9 tice if the group practice reports measures de-  
10 termined appropriate by the Secretary under  
11 such subsection.

12 “(E) COORDINATION WITH EXISTING PRO-  
13 GRAMS.—The application of measures and clin-  
14 ical practice improvement activities and assess-  
15 ment of performance under this subsection  
16 shall, as appropriate, be coordinated with the  
17 application of measures and assessment of per-  
18 formance under other provisions of this section.

19 “(2) ASSESSING PERFORMANCE WITH RESPECT  
20 TO FINAL QUALITY MEASURE SETS FOR APPLICABLE  
21 PEER COHORTS.—

22 “(A) ESTABLISHMENT OF METHODS FOR  
23 ASSESSMENT.—

24 “(i) IN GENERAL.—Under the update  
25 incentive program, the Secretary shall—

1                   “(I) establish one or more meth-  
2                   ods, applicable with respect to a per-  
3                   formance period, to assess (using a  
4                   scoring scale of 0 to 100) the per-  
5                   formance of an eligible professional  
6                   with respect to, subject to paragraph  
7                   (1)(D), quality measures and clinical  
8                   practice improvement activities in-  
9                   cluded within the final quality meas-  
10                  ure set published under subsection  
11                  (k)(9)(F) applicable for the period to  
12                  the peer cohort in which the provider  
13                  self-identified under subsection  
14                  (k)(9)(B) for such period; and

15                  “(II) subject to paragraph  
16                  (1)(D), compute a composite score for  
17                  such provider for such performance  
18                  period with respect to the measures  
19                  and activities included within such  
20                  measure set.

21                  “(ii) METHODS.—Such methods shall,  
22                  with respect to an eligible professional,  
23                  provide that the performance of such pro-  
24                  fessional shall, subject to paragraph  
25                  (1)(D), be assessed for a performance pe-

1                   riod with respect to the quality measures  
2                   and clinical practice improvement activities  
3                   within the final quality measure set for  
4                   such period for the peer cohort of such  
5                   professional and on which information is  
6                   collected from such professional.

7                   “(iii) WEIGHTING OF MEASURES.—  
8                   Such a method may provide for the assign-  
9                   ment of different scoring weights or, as ap-  
10                  propriate, other factors—

11                  “(I) for quality measures and  
12                  clinical practice improvement activi-  
13                  ties;

14                  “(II) based on the type or cat-  
15                  egory of measure or activity; and

16                  “(III) based on the extent to  
17                  which a quality measure or clinical  
18                  practice improvement activity mean-  
19                  ingfully assesses quality.

20                  “(iv) RISK ADJUSTMENT.—Such a  
21                  method shall provide for appropriate risk  
22                  adjustments.

23                  “(v) INCORPORATION OF OTHER  
24                  METHODS OF MEASURING PHYSICIAN  
25                  QUALITY.—In establishing such methods,

1                   there shall be, as appropriate, incorporated  
2                   comparable methods of measurement from  
3                   physician quality incentive programs, such  
4                   as under subsections (k) and (m).

5                   “(B) PERFORMANCE PERIOD.—There shall  
6                   be established a period (in this subsection re-  
7                   ferred to as a ‘performance period’), with re-  
8                   spect to a year (beginning with 2019) for which  
9                   the quality adjustment is applied under para-  
10                  graph (3), to assess performance on quality  
11                  measures and clinical practice improvement ac-  
12                  tivities. Each such performance period shall be  
13                  a period of 12 consecutive months and shall end  
14                  as close as possible to the beginning of the year  
15                  for which such adjustment is applied.

16                  “(3) QUALITY ADJUSTMENT TAKING INTO AC-  
17                  COUNT QUALITY ASSESSMENTS.—

18                  “(A) QUALITY ADJUSTMENT.—For pur-  
19                  poses of subsection (d)(16), if the composite  
20                  score computed under paragraph (2)(A) for an  
21                  eligible professional for a year (beginning with  
22                  2019) is—

23                                 “(i) a score of 67 or higher, the qual-  
24                                 ity adjustment under this paragraph for

1 the eligible professional and year is 1 per-  
2 centage point;

3 “(ii) a score of at least 34, but below  
4 67, the quality adjustment under this  
5 paragraph for the eligible professional and  
6 year is zero; or

7 “(iii) a score below 34, the quality ad-  
8 justment under this paragraph for the eli-  
9 gible professional and year is -1 percentage  
10 point.

11 “(B) NO EFFECT ON SUBSEQUENT YEARS’  
12 QUALITY ADJUSTMENTS.—Each such quality  
13 adjustment shall be made each year without re-  
14 gard to the update adjustment for a previous  
15 year under this paragraph.

16 “(4) TRANSITION FOR NEW ELIGIBLE PROFES-  
17 SIONALS.—In the case of a physician, practitioner,  
18 or other supplier that first becomes an eligible pro-  
19 fessional (and had not previously submitted claims  
20 under this title as a person, as an entity, or as part  
21 of a physician group or under a different billing  
22 number or tax identifier)—

23 “(A) during the first performance period,  
24 with respect to a year, during any part of which  
25 the physician, practitioner, or other supplier is

1 an eligible professional, the quality adjustment  
2 under this paragraph shall be, for each such  
3 year, 0; and

4 “(B) in any part of a subsequent year, the  
5 quality adjustment shall be during a period (not  
6 to exceed a 1-year period) and in such amount  
7 as specified.

8 “(5) FEEDBACK.—

9 “(A) FEEDBACK.—

10 “(i) ONGOING FEEDBACK.—Under the  
11 process under subsection (m)(5)(H), there  
12 shall be provided, as real time as possible,  
13 but at least quarterly, to each eligible pro-  
14 fessional feedback—

15 “(I) on the performance of such  
16 provider with respect to quality meas-  
17 ures and clinical practice improvement  
18 activities within the final quality  
19 measure set published under sub-  
20 section (k)(9)(F) for the applicable  
21 performance period and the peer co-  
22 hort of such professional; and

23 “(II) to assess the progress of  
24 such professional under the update in-

1                   centive program with respect to a per-  
2                   formance period for a year.

3                   “(ii) USE OF REGISTRIES AND OTHER  
4                   MECHANISMS.—Feedback under this sub-  
5                   paragraph shall, to the extent an eligible  
6                   professional chooses to participate in a  
7                   data registry for purposes of this sub-  
8                   section (including registries under sub-  
9                   sections (k) and (m)), be provided and  
10                  based on performance received through the  
11                  use of such registry, and to the extent that  
12                  an eligible professional chooses not to par-  
13                  ticipate in such a registry for such pur-  
14                  poses, be provided through other similar  
15                  mechanisms that allow for the provision of  
16                  such feedback and receipt of such perform-  
17                  ance information.

18                  “(B) DATA MECHANISM.—Under the up-  
19                  date incentive program, there shall be developed  
20                  an electronic interactive eligible professional  
21                  mechanism through which such a professional  
22                  may receive performance data, including data  
23                  with respect to performance on the measures  
24                  and activities developed and selected under this  
25                  section. Such mechanism shall be developed in

1           consultation with private payers and health in-  
2           surance issuers (as defined in section  
3           2791(b)(2) of the Public Health Service Act) as  
4           appropriate.

5           “(C) TRANSFER OF FUNDS.—The Sec-  
6           retary shall provide for the transfer of  
7           \$100,000,000 from the Federal Supplementary  
8           Medical Insurance Trust Fund established in  
9           section 1841 to the Center for Medicare & Med-  
10          icaid Services Program Management Account to  
11          support such efforts to develop the infrastruc-  
12          ture as necessary to carry out subsection (k)(9)  
13          and this subsection and for purposes of section  
14          1889(h). Such funds shall be so transferred on  
15          the date of the enactment of this subsection  
16          and shall remain available until expended.”.

17          (B) INCENTIVE TO REPORT UNDER UIP.—  
18          Section 1848(a)(8)(A) of the Social Security  
19          Act is amended—

20                  (i) in clause (i), by striking “With re-  
21                  spect to” and inserting “Subject to clause  
22                  (iii), with respect to”; and

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

1                   “(iii) APPLICATION TO ELIGIBLE PRO-  
2                   FESSIONALS NOT REPORTING.—With re-  
3                   spect to covered professional services (as  
4                   defined in subsection (k)(3)) furnished by  
5                   an eligible professional during 2019 or any  
6                   subsequent year, if the eligible professional  
7                   does not submit data for the performance  
8                   period (as defined in subsection (q)(2)(B))  
9                   with respect to such year on, subject to  
10                  subsection (q)(1)(D), the quality measures  
11                  and, as applicable, clinical practice im-  
12                  provement activities within the final qual-  
13                  ity measure set under subsection (k)(9)(F)  
14                  applicable to the peer cohort of such pro-  
15                  vider, the fee schedule amount for such  
16                  services furnished by such professional  
17                  during the year (including the fee schedule  
18                  amount for purposes of determining a pay-  
19                  ment based on such amount) shall be equal  
20                  to 95 percent (in lieu of the applicable per-  
21                  cent) of the fee schedule amount that  
22                  would otherwise apply to such services  
23                  under this subsection (determined after ap-  
24                  plication of paragraphs (3), (5), and (7),  
25                  but without regard to this paragraph). The

1 Secretary shall develop a minimum per  
2 year caseload threshold, with respect to eli-  
3 gible professionals, and the previous sen-  
4 tence shall not apply to eligible profes-  
5 sionals with a caseload for a year below  
6 such threshold for such year.”.

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

11 “(h) UPDATE INCENTIVE PROGRAM.—Under this  
12 section, information shall be disseminated to educate and  
13 assist eligible professionals (as defined in section  
14 1848(k)(3)) about the update incentive program under  
15 section 1848(q) and quality measures under section  
16 1848(k)(9) through multiple approaches, including a na-  
17 tional dissemination strategy and outreach by medicare  
18 contractors.”.

19 (4) CONFORMING AMENDMENTS.—

20 (A) TREATMENT OF SATISFACTORILY RE-  
21 PORTING PQRS MEASURES THROUGH PARTICI-  
22 PATION IN A QUALIFIED CLINICAL DATA REG-  
23 ISTRY.—Section 1848(m)(3)(D) of the Social  
24 Security Act (42 U.S.C. 1395w-4(m)(3)(D)) is  
25 amended by striking “For 2014 and subsequent

1 years” and inserting “For each of 2014  
2 through 2018”.

3 (B) COORDINATING ENHANCED PQRS RE-  
4 PORTING WITH EHR.—Section  
5 1848(o)(2)(B)(iii) of the Social Security Act  
6 (42 U.S.C. 1395w-4(o)(2)(B)(iii)) is amended  
7 by striking “subsection (k)(2)(C)” and inserting  
8 “subparagraph (C) or (D) of subsection  
9 (k)(2)”.

10 (C) COORDINATING PQRS REPORTING PE-  
11 RIOD WITH UPDATE INCENTIVE PROGRAM PER-  
12 FORMANCE PERIOD.—Section 1848(m)(6)(C) of  
13 the Social Security Act (42 U.S.C. 1395w-  
14 4(m)(6)(C)) is amended—

15 (i) in clause (i), by striking “and (iii)”  
16 and inserting “, (iii), and (iv)”;

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

19 “(iv) COORDINATION WITH UPDATE  
20 INCENTIVE PROGRAM.—For 2019 and each  
21 subsequent year the reporting period shall  
22 be coordinated with the performance period  
23 under subsection (q)(2)(B).”.

24 (D) COORDINATING EHR REPORTING WITH  
25 UPDATE INCENTIVE PROGRAM PERFORMANCE

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

7 (c) **ADVANCING ALTERNATIVE PAYMENT MODELS.—**

8 (1) **IN GENERAL.**—Part B of title XVIII of the  
9 Social Security Act (42 U.S.C. 1395w–4 et seq.) is  
10 amended by adding at the end the following new sec-  
11 tion:

12 **“SEC. 1848A. ADVANCING ALTERNATIVE PAYMENT MODELS.**

13 “(a) **PAYMENT MODEL CHOICE PROGRAM.**—Pay-  
14 ment for covered professional services (as defined in sec-  
15 tion 1848(k)) that are furnished by an eligible professional  
16 (as defined in such section) under an Alternative Payment  
17 Model specified on the list under subsection (h) (in this  
18 section referred to as an ‘eligible APM’) shall be made  
19 under this title in accordance with the payment arrange-  
20 ment under such model. In applying the previous sentence,  
21 such a professional with such a payment arrangement in  
22 effect, shall be deemed for purposes of section 1848(a)(8)  
23 to be satisfactorily submitting data on quality measures  
24 for such covered professional services.

1           “(b) PROCESS FOR IMPLEMENTING ELIGIBLE  
2 APMs.—

3           “(1) IN GENERAL.—For purposes of subsection  
4 (a) and in accordance with this section, the Sec-  
5 retary shall establish a process under which—

6                   “(A) a contract is entered into, in accord-  
7 ance with paragraph (2).

8                   “(B) proposals for potential Alternative  
9 Payment Models are submitted in accordance  
10 with subsection (c);

11                   “(C) Alternative Payment Models so pro-  
12 posed are recommended, in accordance with  
13 subsection (d), for evaluation, including through  
14 the demonstration program under subsection  
15 (e), and approval under subsection (f);

16                   “(D) applicable Alternative Payment Mod-  
17 els are evaluated under such demonstration pro-  
18 gram;

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

21                   “(F) a comprehensive list of all eligible  
22 APMs is made publicly available, in accordance  
23 with subsection (h), for application under sub-  
24 section (a).

1           “(2) CONTRACT WITH APM CONTRACTING ENTI-  
2           TY.—

3                   “(A) IN GENERAL.—For purposes of para-  
4                   graph (1)(A), the Secretary shall identify and  
5                   have in effect a contract with an independent  
6                   entity that has appropriate expertise to carry  
7                   out the functions applicable to such entity  
8                   under this section. Such entity shall be referred  
9                   to in this section as the ‘APM contracting enti-  
10                  ty’.

11                   “(B) TIMING FOR FIRST CONTRACT.—As  
12                   soon as practicable, but not later than one year  
13                   after the date of the enactment of this section,  
14                   the Secretary shall enter into the first contract  
15                   under subparagraph (A).

16                   “(C) COMPETITIVE PROCEDURES.—Com-  
17                   petitive procedures (as defined in section 4(5)  
18                   of the Office of Federal Procurement Policy Act  
19                   (41 U.S.C. 403(5)) shall be used to enter into  
20                   a contract under subparagraph (A).

21                   “(c) SUBMISSION OF PROPOSED ALTERNATIVE PAY-  
22                   MENT MODELS.—Beginning not later than 90 days after  
23                   the date the Secretary enters into a contract under sub-  
24                   section (b)(2) with the APM contracting entity, physi-  
25                   cians, eligible professional organizations, health care pro-

1 vider organizations, and other entities may submit to the  
2 APM contracting entity proposals for Alternative Payment  
3 Models for application under this section. Such a proposal  
4 of a model shall include suggestions for measures to be  
5 used under subsection (e)(1)(B) for purposes of evaluating  
6 such model. In reviewing submissions under this sub-  
7 section for purposes of making recommendations under  
8 subsection (d)(1), the contracting entity shall focus on  
9 submissions for such models that are intended to improve  
10 care coordination and quality for patients through modi-  
11 fying the manner in which physicians and other providers  
12 are paid under this title.

13 “(d) RECOMMENDATION BY APM CONTRACTING EN-  
14 TITY OF PROPOSED MODELS.—

15 “(1) RECOMMENDATION.—

16 “(A) IN GENERAL.—Under the process  
17 under subsection (b), the APM contracting enti-  
18 ty shall at least annually recommend to the  
19 Secretary—

20 “(i) based on the criteria described in  
21 subparagraph (B), Alternative Payment  
22 Models submitted under subsection (c) to  
23 be evaluated through a demonstration pro-  
24 gram under subsection (e); and

1                   “(ii) based on the criteria described in  
2                   subparagraph (C), Alternative Payment  
3                   Models submitted under subsection (e) for  
4                   purposes of implementation under sub-  
5                   section (f), without evaluation through  
6                   such a demonstration program.

7                   Such a recommendation may be made with re-  
8                   spect to a model for which a waiver would be  
9                   required under paragraph (2).

10                   “(B) CRITERIA FOR RECOMMENDING MOD-  
11                   ELS FOR DEMONSTRATION.—The APM con-  
12                   tracting entity shall make a recommendation  
13                   under subparagraph (A)(i), with respect to an  
14                   Alternative Payment Model, only if the entity  
15                   determines that the model satisfies each of the  
16                   following criteria:

17                   “(i) The model has been supported by  
18                   meaningful clinical and non-clinical data,  
19                   with respect to a sufficient population sam-  
20                   ple, that indicates the model would be suc-  
21                   cessful at addressing each of the abilities  
22                   described in clause (v).

23                   “(ii) (I) In the case of a model that  
24                   has already been evaluated and supported  
25                   by data with respect to a population of in-

1 individuals enrolled under this part, if the  
2 model were evaluated under the dem-  
3 onstration under subsection (e) such a  
4 population would represent a sufficient  
5 number of individuals enrolled under this  
6 part to ensure meaningful evaluation.

7 “(II) In the case of a model that has  
8 not been so evaluated and supported by  
9 data with respect to such a population, the  
10 population that would be furnished services  
11 under such model if the model were evalu-  
12 ated under the demonstration under sub-  
13 section (e) would represent a sufficient  
14 number of individuals enrolled under this  
15 part to ensure meaningful evaluation.

16 “(iii) Such model, including if evalu-  
17 ated under the demonstration under sub-  
18 section (e), would not deny or limit the  
19 coverage or provision of benefits under this  
20 title for applicable individuals.

21 “(iv) The implementation of such  
22 model as an eligible APM under this sec-  
23 tion is expected—

1 “(I) to reduce spending under  
2 this title without reducing the quality  
3 of care; or

4 “(II) improve the quality of pa-  
5 tient care without increasing spend-  
6 ing;

7 “(v) The proposal for such model  
8 demonstrates—

9 “(I) the potential to successfully  
10 manage the cost of furnishing items  
11 and services under this title so as to  
12 not result in expenditures under this  
13 title for individuals participating  
14 under such APM being greater than  
15 expenditures under this title for such  
16 individuals if the APM were not im-  
17 plemented;

18 “(II) the ability to maintain or  
19 improve the overall patient care; and

20 “(III) the ability to maintain or  
21 improve the quality of care provided  
22 to individuals enrolled under this part  
23 who participate under such mode.

24 “(vi) The model provides for a pay-  
25 ment arrangement—

1                   “(I) covering at least items and  
2                   services furnished under this part by  
3                   eligible professionals participating in  
4                   the model;

5                   “(II) in the case such payment  
6                   arrangement does not provide for pay-  
7                   ment under the fee schedule under  
8                   section 1848 for such items and serv-  
9                   ices furnished by such eligible profes-  
10                  sionals, that provides for a payment  
11                  adjustment based on meaningful EHR  
12                  use comparable to such adjustment  
13                  that would otherwise apply under sec-  
14                  tion 1848; and

15                  “(III) that provides for a pay-  
16                  ment adjustment based on quality  
17                  measures comparable to such adjust-  
18                  ment that would otherwise apply  
19                  under section 1848.

20                  “(C) CRITERIA FOR RECOMMENDING MOD-  
21                  ELS FOR APPROVAL WITHOUT EVALUATION  
22                  UNDER DEMONSTRATION.—The APM con-  
23                  tracting entity may make a recommendation  
24                  under subparagraph (A)(ii), with respect to an  
25                  Alternative Payment Model, only if the entity

1 determines that the model has already been  
2 evaluated for a sufficient enough period and  
3 through such evaluation the model was shown—

4 “(i) to have satisfied the criteria de-  
5 scribed in each of clauses (i), (ii), (iii), and  
6 (vi) of subparagraph (B);

7 “(ii) to demonstrate each of the abili-  
8 ties described in clause (v) of such sub-  
9 paragraph; and

10 “(iii)(I) to reduce spending under this  
11 title without reducing the quality of care;

12 or

13 “(II) improve the quality of patient  
14 care without increasing spending.

15 “(D) TRANSPARENCY AND DISCLO-  
16 SURES.—

17 “(i) DISCLOSURES.—Not later than  
18 90 days after receipt of a submission of a  
19 model under subsection (c) by an entity,  
20 the APM contracting entity shall submit to  
21 the Secretary and such entity and make  
22 publicly available a notification on whether  
23 or not, and if so how, the model meets cri-  
24 teria for recommending such model under  
25 subparagraph (A), including whether or

1 not such model requires a waiver under  
2 paragraph (2). In the case that the APM  
3 contracting entity determines not to rec-  
4 ommend such model under this paragraph,  
5 such notification shall include an expla-  
6 nation of the reasons for not making such  
7 a recommendation. Any information made  
8 publicly available pursuant to the previous  
9 sentence shall not include proprietary data.

10 “(ii) SUBMISSION OF RECOMMENDED  
11 MODELS.—The APM contracting entity  
12 shall at least quarterly submit to the Sec-  
13 retary, the Medicare Payment Advisory  
14 Commission, and the Chief Actuary of the  
15 Centers for Medicare & Medicaid Services  
16 the following:

17 “(I) The models recommended  
18 under subparagraph (A)(i), including  
19 any such models that require a waiver  
20 under paragraph (2), and the data  
21 and analyses on such recommended  
22 models that support the criteria de-  
23 scribed in subparagraph (B).

24 “(II) The models recommended  
25 under subparagraph (A)(ii), including

1 any such models that require a waiver  
2 under paragraph (2), and the data  
3 and analyses on such recommended  
4 models that support the criteria de-  
5 scribed in subparagraph (C).

6 For any year beginning with 2015 that the  
7 APM contracting does not recommend any  
8 models under subparagraph (A), the entity  
9 shall instead satisfy this clause by submit-  
10 ting to the Secretary and making publicly  
11 available an explanation for not having any  
12 such recommendations.

13 “(2) MODELS REQUIRING WAIVER APPROVAL.—

14 “(A) IN GENERAL.—In the case that an  
15 Alternative Payment Model recommended under  
16 paragraph (1)(A)(i) would require a waiver  
17 from any requirement under this title, in deter-  
18 mining approval of such model, the Secretary  
19 may make such a waiver in order for such  
20 model to be evaluated under the demonstration  
21 program (if described in clause (i) of such para-  
22 graph).

23 “(B) APPROVAL.—Not later than 90 days  
24 after the date of the receipt of such submission  
25 for a model, the Secretary shall notify the APM

1           contracting entity and the entity submitting  
2           such model under subsection (c) whether or not  
3           such a waiver for such model is provided and  
4           the reason for any denial of such a waiver.

5           “(e) DEMONSTRATION.—

6           “(1) IN GENERAL.—Subject to paragraphs (5),  
7           (6), and (7), the Secretary may conduct a dem-  
8           onstration program, with respect to an Alternative  
9           Payment Model approved under paragraph (2),  
10          under which participating entities shall be paid  
11          under this title in accordance with the payment ar-  
12          rangement under such model and such model shall  
13          be evaluated by the independent evaluation entity  
14          under paragraph (3). The duration of a demonstra-  
15          tion program under this subsection, with respect to  
16          such a model, shall be 3 years (or a shorter period,  
17          taking into account the applicable recommendation  
18          under subsection (d)(1)(A)(i)).

19          “(2) APPROVAL BY SECRETARY OF MODELS  
20          FOR DEMONSTRATION.—Not later than 90 days  
21          after the date of receipt of a recommendation under  
22          subsection (d)(1)(A)(i), with respect to an Alter-  
23          native Payment Model, the Secretary shall approve  
24          such model for a demonstration program under this  
25          subsection only if the Secretary determines the

1 model satisfies the criteria described in subsection  
2 (d)(1)(B). The Secretary shall periodically make a  
3 available a list of such models so approved.

4 “(3) PARTICIPATING ENTITIES.—To participate  
5 under a demonstration program under this sub-  
6 section, with respect to an Alternative Payment  
7 Model, a physician, practitioner, or other supplier  
8 shall enter into a contract with the Administrator of  
9 the Centers for Medicare & Medicaid Services under  
10 this subsection. For purposes of this section, such a  
11 physician, practitioner, or supplier who so partici-  
12 pates under such an Alternative Payment Model  
13 shall be referred to as a ‘participating APM pro-  
14 vider’.

15 “(4) REPORTING AND EVALUATION.—

16 “(A) INDEPENDENT EVALUATION ENTI-  
17 TY.—Under this subsection, the Secretary shall  
18 enter into a contract with an independent entity  
19 to evaluate Alternative Payment Models under  
20 demonstration programs under this subsection  
21 based on appropriate measures specified under  
22 subparagraph (B). In this section, such entity  
23 shall be referred to as the ‘independent evalua-  
24 tion entity’. Such contract shall be entered into  
25 in a timely manner so as to ensure evaluation

1 of an Alternative Payment Model under a dem-  
2 onstration program under this subsection may  
3 begin as soon as possible after the model is ap-  
4 proved under paragraph (2).

5 “(B) PERFORMANCE MEASURES.—For  
6 purposes of this subsection, the Secretary shall  
7 specify—

8 “(i) measures to evaluate Alternative  
9 Payment Models under demonstration pro-  
10 grams under this subsection, which may  
11 include measures suggested under sub-  
12 section (c) and shall be sufficient to allow  
13 for a comprehensive assessment of such a  
14 model; and

15 “(ii) quality measures on which par-  
16 ticipating entities shall report, which shall  
17 be similar to measures applicable under  
18 section 1848(k).

19 “(C) REPORTING REQUIREMENTS.—A con-  
20 tract entered into with a participating APM  
21 provider under paragraph (3) shall require such  
22 provider to report on appropriate measures  
23 specified under subparagraph (B).

24 “(D) PERIODIC REVIEW.—The inde-  
25 pendent evaluation entity shall periodically re-

1 view and analyze and submit such analysis to  
2 the Secretary and the participating entities in-  
3 volved data reported under subparagraph (C)  
4 and such other data as deemed necessary to  
5 evaluate the model.

6 “(E) FINAL EVALUATION.—Not later than  
7 6 months after the date of completion of a dem-  
8 onstration program, the independent evaluation  
9 entity shall submit to the Secretary, the Medi-  
10 care Payment Advisory Commission, and the  
11 Chief Actuary of the Centers for Medicare &  
12 Medicaid Services (and make publicly available)  
13 a report on each model evaluated under such  
14 program. Such report shall include—

15 “(i) outcomes on the clinical and  
16 claims data received through such program  
17 with respect to such model;

18 “(ii) recommendations on—

19 “(I) whether or not such model  
20 should be implemented as an eligible  
21 APM under this section; or

22 “(II) whether or not the evalua-  
23 tion of such model under the dem-  
24 onstration program should be ex-  
25 tended or expanded;

1                   “(iii) the justification for each such  
2                   recommendation described in clause (ii);  
3                   and

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

8                   “(5) APPROVAL OF EXTENDING EVALUATION  
9                   UNDER DEMONSTRATION.—Not later than 90 days  
10                  after the date of receipt of a submission under para-  
11                  graph (4)(E), the Secretary shall, including based on  
12                  a recommendation submitted under such paragraph,  
13                  determine whether an Alternative Payment Model  
14                  may be extended or expanded under the demonstra-  
15                  tion program.

16                  “(6) TERMINATION.—The Secretary shall ter-  
17                  minate a demonstration program for a model under  
18                  this subsection unless the Secretary determines (and  
19                  the Chief Actuary of the Centers for Medicare &  
20                  Medicaid Services, with respect to program spending  
21                  under this title, certifies), after testing has begun,  
22                  that the model is expected to—

23                               “(A) improve the quality of care (as deter-  
24                               mined by the Administrator of the Centers for

1 Medicare & Medicaid Services) without increas-  
2 ing spending under this title;

3 “(B) reduce spending under this title with-  
4 out reducing the quality of care; or

5 “(C) improve the quality of care and re-  
6 duce spending.

7 Such termination may occur at any time after such  
8 testing has begun and before completion of the test-  
9 ing.

10 “(7) FUNDING.—

11 “(A) IN GENERAL.—There are appro-  
12 priated, from amounts in the Federal Supple-  
13 mentary Medical Insurance Trust Fund under  
14 section 1841 not otherwise appropriated,  
15 \$2,000,000,000 for the purposes described in  
16 subparagraph (B), of which no more than 2.5  
17 percent may be used for the purpose described  
18 in clause (iii) of such subparagraph. Amounts  
19 transferred under this subparagraph shall be  
20 available until expended.

21 “(B) PURPOSES.—Amounts appropriated  
22 under subparagraph (A) shall be used for—

23 “(i) payments for items and services  
24 furnished by participating entities under  
25 an Alternative Payment Model under a

1 demonstration program under this sub-  
2 section that—

3 “(I) would not otherwise be eligi-  
4 ble for payment under this title; or

5 “(II) exceed the amount of pay-  
6 ment that would otherwise be made  
7 for such items and services under this  
8 title if such items and services were  
9 not furnished under such demonstra-  
10 tion program;

11 “(ii) the evaluations provided for  
12 under this section of models under such a  
13 demonstration program;

14 “(iii) payment to the contracting enti-  
15 ty for carrying out its duties under this  
16 section; and

17 “(iv) for otherwise carrying out this  
18 subsection.

19 “(C) LIMITATION.—The amounts appro-  
20 priated under subparagraph (A) are the only  
21 amounts authorized or appropriated to carry  
22 out the purposes described in subparagraph  
23 (B).

24 “(f) IMPLEMENTATION OF RECOMMENDED MODELS  
25 AS ELIGIBLE APMS.—

1           “(1) IN GENERAL.—Not later than the applica-  
2           ble date under paragraph (2), the Secretary shall,  
3           implement an Alternative Payment Model rec-  
4           ommended under subsection (d)(1)(A)(ii) or  
5           (e)(4)(E)(ii)(I) as an eligible APM only if—

6                   “(A) the Secretary determines that such  
7           model is expected to—

8                           “(i) reduce spending under this title  
9                           without reducing the quality of care; or

10                           “(ii) improve the quality of patient  
11                           care without increasing spending;

12                   “(B) the Chief Actuary of the Centers for  
13           Medicare & Medicaid Services certifies that  
14           such expansion would reduce (or would not re-  
15           sult in any increase in) program spending  
16           under this title; and

17                   “(C) the Secretary determines that such  
18           model would not deny or limit the coverage or  
19           provision of benefits under this title for applica-  
20           ble individuals.

21           Not later than 90 days after the date of issuance of  
22           a proposed rule, with respect to an Alternative Pay-  
23           ment Model, the Medicare Payment Advisory Com-  
24           mission shall submit comments to Congress and the  
25           Secretary evaluating the reports from the con-

1       tracting entity and independent evaluation entity on  
2       such model regarding the model’s impact on expend-  
3       itures and quality of care under this title.

4           “(2) APPLICABLE DATE.—For purposes of  
5       paragraph (1), the applicable date under this para-  
6       graph—

7           “(A) for an Alternative Payment Model  
8       recommended under subsection (d)(1)(A)(ii) is  
9       90 days after the date of submission of such  
10      recommendation; and

11          “(B) for an Alternative Payment Model  
12      recommended under subsection (e)(4)(E)(ii)(I)  
13      is 90 days after the date of submission of such  
14      recommendation

15          “(3) JUSTIFICATION FOR DISAPPROVALS.—In  
16      the case that an Alternative Payment Model rec-  
17      ommended under subsection (d)(1)(A)(ii) or  
18      (e)(4)(E)(ii)(I) is not implemented as an eligible  
19      APM under this subsection, the Secretary shall  
20      make publicly available the rational, in detail, for  
21      such decision.

22          “(g) PERIODIC REVIEW AND TERMINATION.—

23           “(1) PERIODIC REVIEW.—In the case of an Al-  
24      ternative Payment Model that has been imple-  
25      mented, the Secretary and the Chief Actuary of the

1 Centers for Medicare & Medicaid Services shall re-  
2 view such Model every 3 years to determine (and  
3 certify, in the case of the Chief Actuary and spend-  
4 ing under this title), for the previous 3 years, wheth-  
5 er the Model has—

6 “(A) reduced the quality of care, or

7 “(B) increased spending under this title,  
8 compared to the quality of care or spending that  
9 would have resulted if the Model had not been imple-  
10 mented.

11 “(2) TERMINATION.—

12 “(A) QUALITY OF CARE REDUCTION TER-  
13 MINATION.—If based upon such review the Sec-  
14 retary determines under paragraph (1)(A) that  
15 the Model has reduced the quality of care, the  
16 Secretary may terminate such Model.

17 “(B) SPENDING INCREASE TERMI-  
18 NATION.—Unless such Chief Actuary certifies  
19 under paragraph (1)(B) that the expenditures  
20 under this title under the Model do not exceed  
21 the expenditures that would otherwise have  
22 been made if the Model had not been imple-  
23 mented for the period involved, the Secretary  
24 shall terminate such Model.

1           “(h) DISSEMINATION OF ELIGIBLE APMS.—Under  
2 this section there shall be established a process for speci-  
3 fying, and making publicly available a list of, all eligible  
4 APMS, which shall include at least those implemented  
5 under subsection (f) and demonstrations carried out with  
6 respect to payments under section 1848 through authority  
7 in existence as of the day before the date of the enactment  
8 of this section. Under such process such list shall be peri-  
9 odically updated and, beginning with January 1, 2015,  
10 and annually thereafter, such list shall be published in the  
11 Federal Register.”.

12           (2) CONFORMING AMENDMENT.—Section  
13 1848(a)(1) of the Social Security Act (42 U.S.C.  
14 1395w-4(a)(1)) is amended by striking “shall in-  
15 stead” and inserting “shall, subject to section  
16 1848A, instead”.

17 **SEC. 3. EXPANDING AVAILABILITY OF MEDICARE DATA.**

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

20           (1) IN GENERAL.—To the extent consistent  
21 with applicable information, privacy, security, and  
22 disclosure laws, beginning with 2014, notwith-  
23 standing the second sentence of paragraph (4)(D) of  
24 section 1874(e) of the Social Security Act (42  
25 U.S.C. 1395kk(e)), a qualified entity may use data

1 received by such entity under such section, and in-  
2 formation derived from the evaluation described in  
3 such paragraph (4)(D), for additional analyses (as  
4 determined appropriate by the Secretary of Health  
5 and Human Services) that such entity may provide  
6 or sell to providers of services and suppliers (includ-  
7 ing for the purposes of assisting providers of services  
8 and suppliers to develop and participate in quality  
9 and patient care improvement activities, including  
10 developing new models of care).

11 (2) DEFINITIONS.—In this subsection:

12 (A) The term “qualified entity” has the  
13 meaning given such term in section 1874(e)(2)  
14 of the Social Security Act (42 U.S.C.  
15 1395kk(e)).

16 (B) The terms “supplier”, “physician”,  
17 and “provider of services” have the meanings  
18 given such terms in subsections (d), (r), and  
19 (u), respectively, of section 1861 of the Social  
20 Security Act (42 U.S.C. 1395x).

21 (b) ACCESS TO MEDICARE DATA TO PROVIDERS OF  
22 SERVICES AND SUPPLIERS TO FACILITATE DEVELOP-  
23 MENT OF ALTERNATIVE PAYMENT MODELS AND TO  
24 QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE  
25 QUALITY IMPROVEMENT.—Consistent with applicable

1 laws and regulations with respect to privacy and other rel-  
2 evant matters, the Secretary shall provide Medicare claims  
3 data (in a form and manner determined to be appropriate)  
4 to—

5 (1) providers of services and suppliers in order  
6 to facilitate the development of new models of care  
7 (including development of alternate payment models,  
8 models for small group specialty practices, and care  
9 coordination models); and

10 (2) qualified clinical data registries under sec-  
11 tion 1848(m)(3)(E)) of the Social Security Act (42  
12 U.S.C. 1395w-4(m)(3)(E)) for purposes of linking  
13 such data with clinical outcomes data and per-  
14 forming analysis and research to support quality im-  
15 provement.

16 **SEC. 4. ENCOURAGING CARE COORDINATION AND MED-**  
17 **ICAL HOMES.**

18 Section 1848(b) of the Social Security Act (42 U.S.C.  
19 1395w-4(b)) is amended by adding at the end the fol-  
20 lowing new paragraph:

21 “(8) ENCOURAGING CARE COORDINATION AND  
22 MEDICAL HOMES.—

23 “(A) IN GENERAL.—In order to promote  
24 the coordination of care by an applicable physi-  
25 cian (as defined in subparagraph (B)) for indi-

1           viduals with complex chronic care needs who  
2           are furnished items and services by multiple  
3           physicians and other suppliers and providers of  
4           services, the Secretary shall—

5                   “(i) develop one or more HCPCS  
6                   codes for complex chronic care manage-  
7                   ment services for individuals with complex  
8                   chronic care needs; and

9                   “(ii) for such services furnished on or  
10                  after January 1, 2015, by an applicable  
11                  physician, make payment (as the Secretary  
12                  determines to be appropriate) under the  
13                  fee schedule under this section using such  
14                  HCPCS codes.

15                  “(B) APPLICABLE PHYSICIAN DEFINED.—  
16                  For purposes of this paragraph, the term ‘ap-  
17                  plicable physician’ means a physician (as de-  
18                  fined in section 1861(r)(1)) who—

19                   “(i) is certified as a medical home (by  
20                   achieving an accreditation status of level 3  
21                   by the National Committee for Quality As-  
22                   surance);

23                   “(ii) is recognized as a patient-cen-  
24                   tered specialty practice by the National  
25                   Committee for Quality Assurance;

1 “(iii) has received equivalent certifi-  
2 cation (as determined by the Secretary); or

3 “(iv) meets such other comparable  
4 qualifications as the Secretary determines  
5 to be appropriate.

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

10 “(D) SINGLE APPLICABLE PHYSICIAN PAY-  
11 MENT.—In carrying out this paragraph, the  
12 Secretary shall only make payment to a single  
13 applicable physician for complex chronic care  
14 management services furnished to an indi-  
15 vidual.”.

16 **SEC. 5. MISCELLANEOUS.**

17 (a) SOLICITATIONS, RECOMMENDATIONS, AND RE-  
18 PORTS.—

19 (1) SOLICITATION FOR RECOMMENDATIONS ON  
20 EPISODES OF CARE DEFINITION.—The Adminis-  
21 trator of the Centers for Medicare & Medicaid Serv-  
22 ices shall request eligible professional organizations  
23 (as defined in section 1848(k)(3) of the Social Secu-  
24 rity Act) and other relevant stakeholders to submit  
25 recommendations for defining non-acute related epi-

1 sodes of care for purposes of applying such defini-  
2 tion under subsections (k) and (q) of section 1848  
3 and section 1848A of the Social Security Act, as  
4 added by subsections (b) and (c) of section 2.

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

7 (A) IN GENERAL.—The Administrator of  
8 the Centers for Medicare & Medicaid Services  
9 shall solicit from eligible professional organiza-  
10 tions (as defined in section 1848(k)(3) of the  
11 Social Security Act recommendations for pay-  
12 ment bundles for chronic conditions and expen-  
13 sive, high volume services for which payment is  
14 made under title XVIII of such Act.

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

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

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

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

4 (i) on the implementation of para-  
5 graph (9) of section 1848(k) of the Social  
6 Security Act, as added by section 2(b)(2),  
7 and the update incentive program under  
8 subsection (q) of section 1848 of the Social  
9 Security Act (42 U.S.C. 1395w-4), as  
10 added by section 2(b)(3);

11 (ii) that includes an evaluation of  
12 such paragraph and such update incentive  
13 program and recommendations with re-  
14 spect to such program and appropriate up-  
15 date mechanisms; and

16 (iii) on the actions taken to promote  
17 and fulfill the identification of opt-out eli-  
18 gible APMs under section 1848A of the  
19 Social Security Act, as added by section  
20 2(c), for application under such section  
21 1848A.

22 (B) GAO AND MEDPAC REPORTS.—

23 (i) GAO REPORT ON INITIAL STAGES  
24 OF PROGRAM.—The Comptroller General  
25 of the United States shall submit to Con-

1           gress a report analyzing the extent to  
2           which the system under section 1848(k)(9)  
3           of the Social Security Act and such update  
4           incentive program under section 1848(q) of  
5           the Social Security Act, as added by sec-  
6           tion 2(b), as of such date, is successfully  
7           satisfying performance objectives, including  
8           with respect to—

9                           (I) the process for developing and  
10                          selecting measures and activities  
11                          under subsection (k)(9) of section  
12                          1848 of such Act;

13                          (II) the process for assessing per-  
14                          formance against such measures and  
15                          activities under subsection (q) of such  
16                          section; and

17                          (III) the adequacy of the meas-  
18                          ures and activities so selected.

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

22                           (I) GAO.—The Comptroller Gen-  
23                          eral of the United States shall each  
24                          evaluate the initial phase of the up-  
25                          date incentive program under sub-

1 section (q) of section 1848 of the So-  
2 cial Security Act and shall submit to  
3 Congress, not later than 2019, a re-  
4 port with recommendations for im-  
5 proving such update incentive pro-  
6 gram.

7 (II) MEDPAC.—In the course of  
8 its March Report to Congress on  
9 Medicare payment policy, MedPAC  
10 shall analyze the initial phase of such  
11 update incentive program and make  
12 recommendations, as appropriate, for  
13 improving such update incentive pro-  
14 gram.

15 (iii) MEDPAC REPORT ON PAYMENT  
16 SYSTEM ALTERNATIVES.—

17 (I) IN GENERAL.—Not later than  
18 June 15, 2016, the Medicare Payment  
19 Advisory Commission shall submit to  
20 Congress a report that analyzes mul-  
21 tiple options for alternative payment  
22 models in lieu of section 1848 of the  
23 Social Security Act (42 U.S.C.  
24 1395w-4). In analyzing such models,  
25 the Medicare Payment Advisory Com-

1 mission shall examine at least the fol-  
2 lowing models:

3 (aa) Accountable care orga-  
4 nization payment models.

5 (bb) Primary care medical  
6 home payment models.

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

10 (dd) Gainsharing arrange-  
11 ments

12 (II) ITEMS TO BE INCLUDED.—

13 Such report shall include information  
14 on how each recommended new pay-  
15 ment model will achieve maximum  
16 flexibility to reward high quality, effi-  
17 cient care.

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

1 Medicaid Services annual reports on such top-  
2 ics.

3 (b) RELATIVE VALUES UNDER THE MEDICARE PHY-  
4 SICIAN FEE SCHEDULE.—

5 (1) ELIGIBLE PHYSICIANS REPORTING SYSTEM  
6 TO IMPROVE ACCURACY OF RELATIVE VALUES.—Sec-  
7 tion 1848(c) of the Social Security Act (42 U.S.C.  
8 1395w-4(c)) is amended by adding at the end the  
9 following new paragraph:

10 “(8) PHYSICIAN REPORTING SYSTEM TO IM-  
11 PROVE ACCURACY OF RELATIVE VALUES.—

12 “(A) IN GENERAL.—The Secretary shall  
13 implement a system for the periodic reporting  
14 by physicians of data on the accuracy of relative  
15 values under this subsection, such as data relat-  
16 ing to service volume and time. Such data shall  
17 be submitted in a form and manner specified by  
18 the Secretary and shall, as appropriate, incor-  
19 porate data from existing sources of data, pa-  
20 tient scheduling systems, cost accounting sys-  
21 tems, and other similar systems.

22 “(B) IDENTIFICATION OF REPORTING CO-  
23 HORT.—Not later than January 1, 2015, the  
24 Secretary shall establish a mechanism for physi-  
25 cians to participate under the reporting system

1 under this paragraph, all of whom shall collec-  
2 tively be referred to under this paragraph as  
3 the ‘reporting group’. The reporting group shall  
4 include physicians across settings that collec-  
5 tively represent a range of specialties and prac-  
6 titioner types, furnish a range of physicians’  
7 services, and serve a range of patient popu-  
8 lations.

9 “(C) INCENTIVE TO REPORT.—Under the  
10 system under this paragraph, the Secretary  
11 may provide for such payments under this part  
12 to physicians included in the reporting group as  
13 the Secretary determines appropriate to com-  
14 pensate such physicians for reporting data  
15 under the system. Such payments shall be pro-  
16 vided in such form and manner as specified by  
17 the Secretary. In carrying out this subpara-  
18 graph, reporting by such a physician under this  
19 paragraph shall not be treated as the furnishing  
20 of physicians’ services for purposes of applying  
21 this section.

22 “(D) FUNDING.—To carry out this para-  
23 graph (other than with respect to payments  
24 made under subparagraph (C)), in addition to  
25 funds otherwise appropriated, the Secretary

1 shall provide for the transfer from the Federal  
2 Supplementary Medical Insurance Trust Fund  
3 under section 1841 of \$1,000,000 to the Cen-  
4 ters for Medicare & Medicaid Services Program  
5 Management Account for each fiscal year begin-  
6 ning with fiscal year 2014. Amounts trans-  
7 ferred under this subparagraph for a fiscal year  
8 shall be available until expended.”.

9 (2) RELATIVE VALUE ADJUSTMENTS FOR  
10 MISVALUED PHYSICIANS’ SERVICES.—

11 (A) IN GENERAL.—Section 1848(c)(2) of  
12 the Social Security Act (42 U.S.C. 1395w-  
13 4(c)(2)) is amended by adding at the end the  
14 following new subparagraph:

15 “(M) ADJUSTMENTS FOR MISVALUED PHY-  
16 SICIANS’ SERVICES.—With respect to fee sched-  
17 ules established for 2016, 2017, and 2018, the  
18 Secretary shall—

19 “(i) identify misvalued services for  
20 which adjustments to the relative values  
21 established under this paragraph would re-  
22 sult in a net reduction in expenditures  
23 under the fee schedule under this section,  
24 with respect to such year, of not more than  
25 1 percent of the projected amount of ex-

1                   penditures under such fee schedule for  
2                   such year; and

3                   “(ii) make such adjustments for each  
4                   such year so as to result in such a net re-  
5                   duction for such year.”.

6                   (B)     BUDGET     NEUTRALITY.—Section  
7                   1848(c)(2)(B)(v) of the Social Security Act (42  
8                   U.S.C. 1395w-4(c)(2)(B)(v)) is amended by  
9                   adding at the end the following new subclause:

10                                 “(VIII)     REDUCTIONS     FOR  
11                                 MISVALUED PHYSICIANS’ SERVICES.—  
12                                 Reduced expenditures attributable to  
13                                 subparagraph (M).”.

14                   (c) CONSTRUCTION REGARDING HEALTH CARE PRO-  
15                   VIDER STANDARDS OF CARE.—

16                   (1) IN GENERAL.—The development, recogni-  
17                   tion, or implementation of any guideline or other  
18                   standard under any Federal health care provision  
19                   shall not be construed to establish the standard of  
20                   care or duty of care owed by a health care provider  
21                   to a patient in any medical malpractice or medical  
22                   product liability action or claim.

23                   (2) DEFINITIONS.—For purposes of this Act:

24                   (A) The term “Federal health care provi-  
25                   sion” means any provision of the Patient Pro-

1           tection and Affordable Care Act (Public Law  
2           111–148), title I and subtitle B of title III of  
3           the Health Care and Education Reconciliation  
4           Act of 2010 (Public Law 111-152), and titles  
5           XVIII and XIX of the Social Security Act.

6           (B) The term “health care provider”  
7           means any individual or entity—

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

11                   (ii) required to be so licensed, reg-  
12                  istered, or certified but that is exempted  
13                  by other statute or regulation.

14           (C) The term “medical malpractice or  
15           medical liability action or claim” means a med-  
16           ical malpractice action or claim (as defined in  
17           section 431(7) of the Health Care Quality Im-  
18           provement Act of 1986 (42 U.S.C. 11151(7)))  
19           and includes a liability action or claim relating  
20           to a health care providers’s prescription or pro-  
21           vision of a drug, device, or biological product  
22           (as such terms are defined in section 201 of the  
23           Federal Food, Drug, and Cosmetic Act or sec-  
24           tion 351 of the Public Health Service Act).

1                   (D) The term “State” includes the District  
2                   of Columbia, Puerto Rico, and any other com-  
3                   monwealth, possession, or territory of the  
4                   United States.

5                   (3) NO PREEMPTION.—No provision of the Pa-  
6                   tient Protection and Affordable Care Act (Public  
7                   Law 111–148), title I or subtitle B of title III of the  
8                   Health Care and Education Reconciliation Act of  
9                   2010 (Public Law 111-152), or title XVIII or XIX  
10                  of the Social Security Act shall be construed to pre-  
11                  empt any State or common law governing medical  
12                  professional or medical product liability actions or  
13                  claims.