AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2810 OFFERED BY MR. CAMP OF MICHIGAN

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 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 quality 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 claims data availability to improve care.
Sec. 9. Reducing administrative burden and other provisions.

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

(a) STABILIZING FEE UPDATES.—

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

(A) in subsection (d)—

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

(ii) in paragraph (4)—

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

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

(B) in subsection (f)—

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

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

(2) UPDATE OF RATES FOR 2014 AND SUBSEQUENT YEARS.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is

amended by adding at the end the following new paragraphs:

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

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

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

''(A) for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) for such year, 2 percent; and

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

(3) MEDPAC REPORTS.—

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

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

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

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

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

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

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(A) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section 1848(a)(7)(A) of the Social 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 2016'';

(ii) in clause (ii)—

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

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

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

(IV) by striking subclause (III); and

(iii) by striking clause (iii).

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

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

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

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

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

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

year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.''.

(2) QUALITY REPORTING.—

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

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

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

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

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

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

(ii) in subsection (m)—

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

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

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

(3) VALUE-BASED PAYMENTS.—

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

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, but before January 1, 2017, with respect to specific physicians and groups of physicians the Secretary determines appropriate. Such payment modifier shall not be

applied for items and services furnished on or after January 1, 2017.''.

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

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

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

(ii) in paragraph (3), by adding at the end the following: ''With respect to 2017 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).''.

(c) VALUE-BASED PERFORMANCE INCENTIVE PROGRAM.—

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

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

''(1) ESTABLISHMENT.—

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

''(i) develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

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

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

paragraph (7) to the professional for the year.

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

''(C) VBP ELIGIBLE PROFESSIONAL DEFINED.—

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

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

''(II) for the third year for which the VBP program applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I) and such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

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

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

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

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

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

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

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

''(II) with respect to 2019 and 2020—

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

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

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

''(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

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

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

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

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

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

''(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible profes-

sional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a VBP eligible professional until the subsequent year and performance period for such subsequent year.

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

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

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

''(D) APPLICATION TO GROUP PRACTICES.—

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

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

''(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for VBP eligible

professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

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

''(iii) CLARIFICATION.—VBP eligible professionals electing to be a virtual group under paragraph (5)(J) shall not be considered VBP eligible professionals in a group practice for purposes of applying this subparagraph.

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

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

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

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

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

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

''(i) Quality.

''(ii) Resource use.

''(iii) Clinical practice improvement activities.

''(iv) Meaningful use of certified EHR technology.

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

''(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures established for such period under subsections (k) and (m), including under subsection (m)(3)(E), and the measures of quality of care established for such period under subsection (p)(2).

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

''(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement ac-

tivities under subcategories specified by the Secretary for such period, which shall include at least the following:

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

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

''(III) The subcategory of care coordination, which shall include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

''(IV) The subcategory of beneficiary engagement, which shall include activities such as the establish-

ment of care plans for individuals with complex care needs, beneficiary self-management training, and using shared decision-making mechanisms.

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

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

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of fewer than 20 professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

''(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection

(o)(2) for determining whether an eligible professional is a meaningful EHR user.

''(C) ADDITIONAL PROVISIONS.—

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

''(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians for purposes of the performance category described in subparagraph (A)(i).

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

''(iv) REQUEST FOR INFORMATION FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit rec-

ommendations from stakeholders for identifying activities described in such subparagraph and specifying criteria for such activities.

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

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

''(II) specifying criteria for such activities; and

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

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

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

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

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

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—Under the VBP program, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for

a performance period (as established under paragraph (4)) for a year.

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

''(i) Historical performance standards.

''(ii) Improvement rates.

''(iii) The opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with the year described in paragraph (1)(B)). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

''(5) COMPOSITE PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013,

the Secretary shall develop a methodology for assessing the total performance of each VBP eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (in this subsection referred to as the 'composite performance score') for each such professional for each performance period.

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

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

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

''(II) each measure and activity specified under paragraph (2)(B) with

respect to each such category based on the extent to which the measure or activity is applicable to the type of eligible professional involved; and

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

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

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

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

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

lowest potential score applicable to such measure or activity.

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

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

''(II) with respect to a performance period, with respect to a year, for which a VBP eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

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

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

''(ii) APM PARTICIPATION.—Participation by a VBP eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period. Nothing in the previous sentence shall prevent such professional from earning more than one-half of such highest potential score for such performance period by performing additional activities with respect to such performance category.

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

''(E) DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in a continuous distribution of performance scores, which shall result in differential payments under paragraph (7).

''(F) ACHIEVEMENT AND IMPROVEMENT.—

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

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

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

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

''(G) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

''(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to clauses (ii) and (iii), the com-

posite performance score shall be determined as follows:

"(I) QUALITY.—Thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A).

"(II) RESOURCE USE.—

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

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

shall be based on performance with respect to such category only for purposes of feedback and zero percent of such score shall be based on performance with respect to such category for any other purpose under this subsection.

''(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

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

''(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined

in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

''(iii) AUTHORITY TO ADJUST PERCENTAGES FOR QUALITY AND RESOURCE USE.—The percentages described in subclauses (I) and (II) of clause (i), including after application of clause (ii), shall be equal.

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

ology described in subsection (r)(5), as appropriate.

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

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

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

''(I) the assessment of performance provided under such methodology with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A) that is to be applied to each such professional in

such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

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

''(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with clause (iii), establish and have in place a process to allow an individual VBP eligible professional or a group practice consisting of not more than 10 VBP eligible professionals to elect, with respect to a performance period for a year, for such individual VBP eligible professional or all such VBP eligible profes-

sionals in such group practice, respectively, to be a virtual group under this subparagraph with at least one other such individual VBP eligible professional or group practice making such an election.

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

''(I) an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period; and

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

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

''(A) TOTAL AMOUNT FOR INCENTIVE PAYMENTS.—The total amount for VBP program incentive payments under paragraph (7) for all VBP eligible professionals for a year shall be equal to the total amount of the performance

funding pool for all VBP eligible professionals under subparagraph (B) for such year, as estimated by the Secretary.

''(B) PERFORMANCE FUNDING POOL.—

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

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

''(I) for 2017, 4 percent;

''(II) for 2018, 6 percent;

''(III) for 2019, 8 percent;

''(IV) for 2020, 10 percent; and

''(V) for 2021 and subsequent years, a percent specified by the Sec-

retary (but in no case less than 10 percent or more than 12 percent).

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

''(7) VBP PROGRAM INCENTIVE PAYMENTS.—

''(A) VBP PROGRAM INCENTIVE PAYMENT ADJUSTMENT FACTOR.—Consistent with section 2(g)(2) of the SGR Repeal and Medicare Beneficiary Access Act of 2013, the Secretary shall specify a VBP program incentive payment adjustment factor for each VBP eligible professional for a year. Such VBP program incentive

payment adjustment factor for a VBP eligible professional for a year shall be determined—

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

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

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

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

''(II) does not result in a payment increase for such year by an

amount that exceeds the applicable percent described in paragraph (6)(B)(ii) for such year.

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

''(i) the product of—

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

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

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

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

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

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

formance funding pool for such year under paragraph (6), as estimated by the Secretary.

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

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

''(10) PUBLIC REPORTING.—

''(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make avail-

able on the Physician Compare Internet website under subsection (t) the following:

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

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

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

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

"(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible

professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

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

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

''(11) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the VBP program, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and

(7). Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

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

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

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

''(ii) how to transition to the implementation of and participation in an alter-

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

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

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

''(A) PERFORMANCE FEEDBACK.—

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

''(I) shall make available timely (such as quarterly) confidential feedback to each VBP eligible professional on the performance of such professional with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

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

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

''(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a VBP eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

''(iv) DISCLOSURE EXEMPTION.—Feedback made available under this sub-

paragraph shall be exempt from disclosure under section 552 of title 5, United States Code.

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

''(B) ADDITIONAL INFORMATION.—

''(i) IN GENERAL.—Beginning July 1, 2016, the Secretary shall make available to each VBP eligible professional information, with respect to individuals who are patients of such VBP eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information shall be made available under the previous sentence to such VBP eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information shall be made available

in accordance with the same or similar terms as data are made available to accountable care organizations under section 1899, including a beneficiary opt-out.

''(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

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

''(II) Historical averages (and other measures of the distribution if

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

''(14) REVIEW.—

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

''(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the VBP program incentive payment adjustment factor under paragraph (7) and the determination of such amount.

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

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

''(iv) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (10).

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

measures and activities under such methodology.''.

(2) GAO REPORTS.—

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

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

(ii) provide recommendations for improving such program.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRI-

VATE PROGRAMS.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that—

(i) compares the similarities and differences in the use of quality measures under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, and private payer arrangements; and

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

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

under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

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

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

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

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

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

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

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

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

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

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

''(1) PAYMENT INCENTIVE.—

''(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2017 and ending with 2022 and for which the professional is a qualifying APM participant, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the payment amount for the covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish poli-

cies to implement this subparagraph in cases where payment for covered professional services furnished by a qualifying APM participant in an alternative payment model is made to an entity participating in the alternative payment model rather than directly to the qualifying APM participant.

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

''(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

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

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

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

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

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

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

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

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

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

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

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

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the preceding year were attributable to such services furnished under this part through an entity that participates in an eligible al-

ternative payment model with respect to such services; and

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

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

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

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

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

''(bb) certified EHR technology is used; and

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

''(C) BEGINNING IN 2021.—With respect to 2021 and each subsequent year, an eligible professional described in either of the following clauses:

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

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

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

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

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

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

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

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

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

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

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

made under an eligible alternative payment model; and

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

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

''(bb) certified EHR technology is used; and

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

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

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

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

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

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

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

''(iii) A demonstration under section 1866C.

''(iv) A demonstration required by Federal law.

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

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

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

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

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

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

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

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

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

''(A) The determination that an eligible professional is a qualifying APM participant

under paragraph (2) and the determination that an alternative payment model is an eligible alternative payment model under paragraph (3)(D).

''(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.''.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

(g) IMPROVING PAYMENT ACCURACY.—

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

(A) STUDY USING EXISTING MEDICARE DATA.—

(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the As-

sistant Secretary for Planning and Evaluation.

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

(B) STUDY USING OTHER DATA.—

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

(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act,

the Secretary shall submit to Congress a report on the study conducted under clause (i).

(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

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

(i) obtain access to the necessary data (if such data is not already being collected) on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

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

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

(2) CMS ACTIVITIES.—

(A) HIERARCHAL CONDITION CATEGORY (HCC) IMPROVEMENT.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1), the Secretary, on an ongoing basis, shall estimate

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

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

(i) IN GENERAL.—Taking into account the studies conducted and recommendations made in reports under paragraph (1), the Secretary shall account for identified factors (other than those applied under subparagraph (A)) with an effect on quality and resource use outcome measures when determining payment adjustments under the eligible professional value-based performance incentive program under section 1848(q) of the Social Security Act and, as the Secretary determines appro-

priate, other similar provisions of title XVIII of such Act.

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

(iii) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in clause (i) so as to monitor changes in possible relationships.

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

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

cial Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(h) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (c), is further amended by adding at the end the following new subsection:

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

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

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

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

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

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

''(i) distinct care episode groups; and

''(ii) distinct patient condition groups.

''(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

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

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

''(II) assign codes to such groups.

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

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

curs, and the principal procedures or services planned or furnished; and

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

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

"(I) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

"(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

"(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 120 days after the end

of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

''(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

''(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 120 days after the end

of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

''(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

''(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in

whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

''(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

''(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

''(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care

furnished by other physicians or practitioners for the patient during an acute episode;

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

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

''(v) furnishes items and services only as ordered by another physician or practitioner.

''(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant

to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

''(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 120 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

''(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2016), the Secretary shall, through rulemaking, make revisions to the operational list of patient

relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2016, shall, as determined appropriate by the Secretary, include—

''(A) applicable codes established under paragraphs (2) and (3); and

''(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

''(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

''(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with re-

spect to care episode and patient condition groups), the Secretary shall—

''(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

''(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

''(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

''(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

''(i) use the claims data experience of such patients by patient condition codes

during a common period, such as 12 months; and

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

''(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

''(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

''(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

''(i) shall use per patient total allowed amounts for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

''(ii) may, as determined appropriate, use other measures of allowed amounts

(such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

''(6) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) care episode and patient condition groups and codes established under paragraph (2);

''(B) patient relationship categories and codes established under paragraph (3); and

''(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(8) DEFINITIONS.—In this section:

''(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

''(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

''(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)); and

''(ii) beginning January 1, 2017, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

''(9) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.''.

SEC. 3. PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (h) of section 2, is further amended by inserting at the end the following new subsection:

''(s) PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT.—

''(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

''(A) DRAFT MEASURE DEVELOPMENT PLAN.—

''(i) DRAFT PLAN.—

''(I) IN GENERAL.—Not later than October 1, 2014, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions.

''(II) REQUIREMENT.—Such plan shall address how measures used by private payers and integrated delivery systems could be incorporated under such subsection.

''(ii) CONSIDERATION.—In developing the draft plan under subparagraph (A), the Secretary shall consider—

''(I) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities; and

''(II) whether measures are applicable across health care settings.

''(iii) PRIORITIES.—In developing the draft plan under subparagraph (A), the Secretary shall give priority to the following types of measures:

''(I) Outcome measures including patient reported outcome and functional status measures.

''(II) Patient experience measures.

''(III) Care coordination measures.

''(IV) Measures of appropriate use of services, including measures of over use.

''(iv) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term

'applicable provisions' means the following provisions:

''(I) Subsection (q)(2)(B)(i).

''(II) Section 1833(z)(2)(C).

''(B) STAKEHOLDER INPUT.—The Secretary shall accept through December 1, 2014, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

''(C) OPERATIONAL MEASURE DEVELOPMENT PLAN.—Not later than February 1, 2015, taking into account the comments received under subparagraph (B), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under subsection (q)(2)(A)(i).

''(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding quality measures for application under the applicable provisions.

Such entities may include physician specialty societies and other practitioner organizations.

''(B) PRIORITIZATION.—

''(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(A)(iii).

''(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider whether such measures would be electronically specified.

''(3) ANNUAL REPORT BY THE SECRETARY.—

''(A) IN GENERAL.—Not later than February 1, 2016, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

''(B) REQUIREMENTS.—Each report submitted pursuant to paragraph (1) shall include the following:

''(i) A description of the Secretary's efforts to implement this subsection.

''(ii) With respect to the measures developed during the previous year—

''(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

''(II) the name of each measure developed;

''(III) the name of the developer and steward of each measure;

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

''(V) whether the measure would be electronically specified.

''(iii) With respect to measures in development at the time of the report—

''(I) the information described in clause (ii), if available; and

''(II) a timeline for completion of the development of such measures.

''(iv) An update on the progress in developing the types of measures described in paragraph (1)(A)(iii), including a description of issues affecting such progress.

''(v) A list of quality topics and concepts that are being considered for development of measures and the rationale for the selection of topics and concepts including their relationship to gap analyses.

''(vi) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

''(vii) Other information the Secretary determines to be appropriate.

''(4) STAKEHOLDER INPUT.—With respect to measures applicable under the applicable provisions, the Secretary shall seek stakeholder input with respect to—

''(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(A)(iii);

''(B) prioritizing quality measure development to address such gaps; and

''(C) other areas related to quality measure development determined appropriate by the Secretary.

''(5) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2021.''.

SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.

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

''(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

''(A) IN GENERAL.—In order to encourage the management of care by an applicable provider (as defined in subparagraph (B)) for indi-

viduals with chronic care needs the Secretary shall—

"(i) establish one or more HCPCS codes for chronic care management services for such individuals; and

"(ii) subject to subparagraph (D), make payment (as the Secretary determines to be appropriate) under this section for such management services furnished on or after January 1, 2015, by an applicable provider.

"(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), or clinical nurse specialist (as defined in section 1861(aa)(5)(B)) who furnishes services as part of a patient-centered medical home or a comparable specialty practice that—

"(i) is recognized as such a medical home or comparable specialty practice by an organization that is recognized by the

Secretary for purposes of such recognition as such a medical home or practice; or

''(ii) meets such other comparable qualifications as the Secretary determines to be appropriate.

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

''(D) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

''(i) make payment to only one applicable provider for such services furnished to an individual during a period;

''(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services (such as in the case of hospice care or home health services); and

''(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive phys-

ical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.''.

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

(a) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

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

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

''(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

''(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

''(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

''(I) Time involved in furnishing services.

''(II) Amounts and types of practice expense inputs involved with furnishing services.

''(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

''(IV) Overhead and accounting information for practices of physicians and other suppliers.

''(V) Any other element that would improve the valuation of services under this section.

''(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

''(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

''(II) Surgical logs, billing systems, or other practice or facility records.

''(III) Electronic health records.

''(IV) Any other mechanism determined appropriate by the Secretary.

''(v) TRANSPARENCY OF USE OF INFORMATION.—

''(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary

shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

''(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

''(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

''(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible profes-

sional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

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

''(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term 'eligible professional' has the meaning given such term in subsection (k)(3)(B).

''(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred

under the preceding sentence for a fiscal year shall be available until expended.''.

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

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

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

''(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).''.

(b) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or

other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).''.

(c) REVISED AND EXPANDED IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—Section 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(K)(ii)) is amended to read as follows:

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

''(I) Codes that have experienced the fastest growth.

''(II) Codes that have experienced substantial changes in practice expenses.

''(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

''(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

''(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

''(VI) Codes that have not been subject to review since implementation of the fee schedule.

''(VII) Codes that account for the majority of spending under the physician fee schedule.

''(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

''(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

''(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

''(XI) Codes for which there may be anomalies in relative values within a family of codes.

''(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

''(XIII) Codes with high intra-service work per unit of time.

''(XIV) Codes with high practice expense relative value units.

''(XV) Codes with high cost supplies.

''(XVI) Codes as determined appropriate by the Secretary.''.

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

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

''(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2015 through 2018, the following shall apply:

''(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

''(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

''(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

''(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in

clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

''(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2015.

''(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

''(I) the target for the year; and

''(II) the estimated net reduction in expenditures determined under clause (i) for the year.

''(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.''.

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

''(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2015, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).''.

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

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

''(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee

schedules established beginning with 2015, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.''.

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

(A) in subparagraph (B)(ii)(I), by striking ''subclause (II)'' and inserting ''subclause (II) and paragraph (7)''; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking ''provisions of subparagraph (B)(ii)(II)'' and inserting ''provisions of subparagraph (B)(ii)(II) and paragraph (7)''; and

(ii) by striking ''under subparagraph (B)(ii)(II)'' and inserting ''under subparagraph (B)(ii)(I)''.

(f) AUTHORITY TO SMOOTH RELATIVE VALUES WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of

the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)) is amended—

(1) in each of clauses (i) and (iii), by striking ''the service'' and inserting ''the service or group of services'' each place it appears; and

(2) in the first sentence of clause (ii), by inserting ''or group of services'' before the period.

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

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

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

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

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

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

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

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

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

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

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

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

''(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A)

for the year (determined without regard to this subparagraph).

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

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

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

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

''(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

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

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

''(ii) Payment locality 3.

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

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

SEC. 6. PROMOTING EVIDENCE-BASED CARE.

(a) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

''(1) PROGRAM ESTABLISHED.—

''(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

''(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term 'appropriate use criteria' means criteria to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

''(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term 'applicable imaging service' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

"(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

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

"(iii) one or more of such mechanisms is available free of charge.

"(D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other outpatient setting determined appropriate by the Secretary.

"(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term 'ordering professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service for an individual.

"(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term 'furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner de-

scribed in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

''(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other entities.

''(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

''(i) have stakeholder consensus;

''(ii) have been determined to be scientifically valid and are evidence based; and

''(iii) are in the public domain.

''(C) REVISIONS.—The Secretary shall periodically update and revise (as appropriate)

such specification of applicable appropriate use criteria.

''(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criteria applies with respect to an applicable imaging service, the Secretary shall specify one or more applicable appropriate use criteria under this paragraph for the service.

''(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(i) IN GENERAL.—The Secretary shall specify one or more qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

''(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, and other stakeholders in specifying mechanisms under this paragraph.

''(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

''(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

''(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

''(III) Use of a clinical decision support mechanism established by the Secretary.

''(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

''(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that

the Secretary determines meets the requirements described in clause (ii).

''(ii) REQUIREMENTS.—The requirements described in this clause are the following:

''(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

''(II) In the case where there are more than one applicable appropriate use criteria specified under such paragraph for an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

''(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

''(IV) The mechanism generates and provides to the ordering professional a certification or documentation

that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

''(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

''(VI) The mechanism meets privacy and security standards under applicable provisions of law.

''(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

''(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

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

''(ii) PERIODIC UPDATING OF LIST.—The Secretary shall periodically update the

list of qualified clinical decision support mechanisms specified under this paragraph.

''(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

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

''(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

''(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subpara-

graph (D)), payment for such service may only be made if the claim for the service includes the following:

''(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

''(ii) Information regarding—

''(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

''(II) whether the service ordered would not adhere to such criteria; or

''(III) whether such criteria was not applicable to the service ordered.

''(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

''(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

''(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an in-

dividual with an emergency medical condition (as defined in section 1867(e)(1)).

''(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

''(iii) ALTERNATIVE PAYMENT MODELS.—An applicable imaging service ordered by an ordering professional with respect to an individual attributed to an alternative payment model (as defined in section 1833(z)(3)(C)).

''(iv) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

''(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term 'applicable payment system' means the following:

''(i) The physician fee schedule established under section 1848(b).

''(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

''(iii) The ambulatory surgical center payment systems under section 1833(i).

''(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

''(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on a periodic basis (which may be annually), ordering professionals who are outlier ordering professionals.

''(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

''(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based

on comparison to other ordering professionals; and

''(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

''(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

''(D) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

''(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

''(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

''(B) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.''.

(2) CONFORMING AMENDMENT.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

''(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(p).''.

(b) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by subsection (a), is amended by adding at the end the following new subsection:

''(q) ESTABLISHMENT OF APPROPRIATE USE PROGRAM FOR OTHER PART B SERVICES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary may establish an appropriate use program for services under this part (other than applicable imaging services under subsection (p)) using a process similar to the process under such subsection.

''(B) REQUIREMENTS.—In determining whether to establish a program under subparagraph (A), the Secretary shall take into consideration—

''(i) the implementation of appropriate use criteria for applicable imaging services under subsection (p); and

''(ii) the report under paragraph (2).

''(C) INPUT FROM STAKEHOLDERS IN ADVANCE OF RULEMAKING.—Before issuing a notice of proposed rulemaking to establish a program under subparagraph (A), the Secretary shall issue an advance notice of proposed rulemaking.

''(2) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of

this subsection, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under this part, such as radiation therapy and clinical diagnostic laboratory services.''.

SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.

(a) TRANSFERRING FREESTANDING PHYSICIAN COMPARE PROVISION TO THE SOCIAL SECURITY ACT.—

(1) IN GENERAL.—Section 10331 of Public Law 111–148 is transferred and redesignated as subsection (t) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (h) of section 2 and by section 3.

(2) CONFORMING REDESIGNATIONS.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as transferred and redesignated by paragraph (1), is further amended—

(A) by striking the subsection heading and inserting the following new subsection heading: ''PUBLIC REPORTING OF PERFORMANCE AND OTHER INFORMATION ON PHYSICIAN COMPARE'';

(B) by redesignating subsections (a) through (i) as paragraphs (1) through (9), respectively, and indenting appropriately;

(C) in paragraph (1), as redesignated by subparagraph (B)—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting appropriately;

(ii) in subparagraph (B), as redesignated by clause (i), by redesignating subparagraphs (A) through (G) as clauses (i) through (vii), respectively, and indenting appropriately;

(D) in paragraph (2), as redesignated by subparagraph (B), by redesignating paragraphs (1) through (7) as subparagraphs (A) through (G), respectively, and indenting appropriately; and

(E) in paragraph (9), as redesignated by subparagraph (B), by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively, and indenting appropriately.

(3) CONFORMING AMENDMENTS.—Section 1848(t) of the Social Security Act (42 U.S.C.

1395w–4(t)), as amended by paragraph (2), is further amended—

(A) in paragraph (1)—

(i) in subparagraph (A)—

(I) by striking ''the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j))'' and inserting ''the program under this title under section 1866(j)''; and

(II) by striking ''of such Act (42 U.S.C. 1395w–4)''; and

(ii) in subparagraph (B), in the matter preceding clause (i)—

(I) by striking ''subsection (c)'' and inserting ''paragraph (3)'';

(II) by striking ''the Medicare program under such section 1866(j)'' and inserting ''the program under this title under section 1866(j)''; and

(III) by striking ''this section'' and inserting ''this subsection'';

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ''subsection (a)(2)'' and inserting ''paragraph (1)(B)'';

(ii) in subparagraph (D), by striking ''the Medicare program'' and inserting ''the program under this title''; and

(iii) in each of subparagraphs (F) and (G), by striking ''this section'' and inserting ''this subsection'';

(C) in paragraph (3), by striking ''this section'' and inserting ''this subsection'';

(D) in paragraph (4)—

(i) by striking ''of the Social Security Act, as added by section 3014 of this Act''; and

(ii) by striking ''this section'' and inserting ''this subsection'';

(E) in paragraph (5)—

(i) by striking ''this subsection (a)(2)'' and inserting ''paragraph (1)(B)''; and

(ii) by striking ''(Public Law 110–275)'';

(F) in paragraph (6), by striking ''subsection (a)(1)'' and inserting ''paragraph (1)(A)'';

(G) in paragraph (7)—

(i) by striking ''subsection (f)'' and inserting ''paragraph (6)''; and

(ii) by striking ''title XVIII of the Social Security Act'' and inserting ''this title'';

(H) in paragraph (8)—

(i) by striking ''subparagraphs (A) through (G) of subsection (a)(2)'' and inserting ''clauses (i) through (vii) of paragraph (1)(B)'';

(ii) by striking ''title XVIII of the Social Security Act'' and inserting ''this title''; and

(iii) by striking ''such title'' and inserting ''this title''; and

(I) in paragraph (9)—

(i) in the matter preceding subparagraph (8), by striking ''this section'' and inserting ''this subsection'';

(ii) in subparagraph (A), by striking ''of the Social Security Act (42 U.S.C. 1395w–4)'';

(iii) in subparagraph (B), by striking ''of such Act (42 U.S.C. 1395x(r))'';

(iv) in subparagraph C), by striking ''subsection (a)(1)'' and inserting ''paragraph (1)(A)''; and

(v) by striking subparagraph (D).

(b) PUBLIC AVAILABILITY OF MEDICARE DATA.—Section 1848(t) of the Social Security Act (42 U.S.C. 1395w–4(t)), as amended by subsection (a), is further amended—

(1) by redesignating paragraph (9) as paragraph (10);

(2) by inserting after paragraph (8) the following new paragraph:

''(9) PUBLIC AVAILABILITY OF ELIGIBLE PROFESSIONAL CLAIMS DATA.—

''(A) IN GENERAL.—The Secretary shall make publicly available on Physician Compare the information described in subparagraph (B) with respect to eligible professionals.

''(B) INFORMATION DESCRIBED.—The following information, with respect to an eligible professional, is described in this subparagraph:

''(i) Information on the number of services furnished by the eligible professional, which may include information on

the most frequent services furnished or groupings of services.

''(ii) Information on submitted charges and payments for services under this part.

''(iii) A unique identifier for the eligible professional that is available to the public, such as a national provider identifier.

''(C) SEARCHABILITY.—The information made available under this paragraph shall be searchable by at least the following:

''(i) The specialty or type of the eligible professional.

''(ii) Characteristics of the services furnished, such as volume or groupings of services.

''(iii) The location of the eligible professional.

''(D) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible profes-

sional, or the health conditions of individuals treated.

''(E) IMPLEMENTATION.—

''(i) INITIAL IMPLEMENTATION.—Physician Compare shall include the information described in subparagraph (B)—

''(I) with respect to physicians, by not later than July 1, 2015; and

''(II) with respect to other eligible professionals, by not later than July 1, 2016.

''(ii) ANNUAL UPDATING.—The information made available under this paragraph shall be updated on Physician Compare not less frequently than on an annual basis.

''(F) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for an eligible professional to review, and submit corrections for, the information to be made public with respect to the eligible professional under this paragraph prior to such information being made public.''; and

(3) in paragraph (10)(C), as redesignated by paragraph (1), by inserting ''(or a successor website)'' before the period at the end.

SEC. 8. EXPANDING CLAIMS DATA AVAILABILITY TO IMPROVE CARE.

(a) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended by adding at the end the following new paragraph:

''(5) EXPANSION OF USES OF CLAIMS DATA BY QUALIFIED ENTITIES.—

''(A) EXPANSION.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2014, notwithstanding paragraph (4)(B) (other than clause (iii) of such paragraph) and the second sentence of paragraph (4)(D), a qualified entity may, as determined appropriate by the Secretary, do any or all of the following:

''(i)(I) Use the combined data described in paragraph (4)(B)(iii) to conduct analyses, other than for reports described in paragraph (4), for entities described in subparagraph (B) for non-public uses, as determined appropriate by the Secretary,

such as for the purposes described in subclause (II).

''(II) The purposes described in this subclause are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities (including developing new models of care), population health management, and disease monitoring, and the purposes described in subparagraph (C).

''(ii) Provide or sell such analyses to entities described in subparagraph (B).

''(iii) Provide entities described in clauses (i), (ii), (v), and (vi) of subparagraph (B) with access to the combined data described in paragraph (4)(B)(iii) through a qualified data enclave (as defined in subparagraph (F)) that is maintained by the qualified entity in order for entities described in such clauses to conduct analyses for non-public uses, such as for the purposes described in clause (i)(II).

''(B) ENTITIES DESCRIBED.—For the purpose of subparagraph (A) clauses (i) and (ii),

the entities described in this subparagraph are the following:

''(i) A provider of services.

''(ii) A supplier.

''(iii) Subject to subparagraph (C), an employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

''(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act) that provides data under paragraph (4)(B)(iii).

''(v) A medical society or hospital association.

''(vi) Other entities approved by the Secretary (other than an employer (as so defined) and a health insurance issuer (as so defined)).

''(C) LIMITATION WITH RESPECT TO EMPLOYERS.—Any analyses provided or sold under this paragraph to an employer (as so defined) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

"(D) PROTECTION OF PATIENT IDENTIFICATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), an analysis provided or sold under this paragraph shall not contain information that individually identifies a patient.

"(ii) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—An analysis that is provided or sold under this paragraph to a provider of services or supplier may contain data that individually identifies a patient of such provider or supplier but only with respect to items and services furnished by such provider or supplier to such patient.

"(iii) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis under this paragraph to an entity described in subparagraph (B), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such

qualified entity shall provide an opportunity for such provider or supplier to review and submit corrections to such analysis.

''(E) NO REDISCLOSURE.—An entity described in subparagraph (B) that is provided or sold an analysis under this paragraph shall not redisclose or make public such an analysis.

''(F) REQUIREMENTS FOR A QUALIFIED DATA ENCLAVE.—

''(i) DEFINITION.—For purposes of this paragraph, the term 'qualified data enclave' means a data enclave that the Secretary determines meets the following:

''(I) The data enclave is a web-based portal or comparable mechanism.

''(II) Subject to the requirements described in clause (ii) and such other requirements as the Secretary may specify, the data enclave is capable of providing access to the combined data described in subparagraph (A)(iii).

''(ii) ENCLAVE ACCESS REQUIREMENTS.—The requirements described in this clause are the following:

''(I) A qualified data enclave shall preclude any entity that obtains access to the data from removing or extracting the data from such enclave.

''(II) Subject to the succeeding sentence, the enclave shall preclude access to data that individually identifies a patient, including data on the patient's name and date of birth and such other data as the Secretary shall specify. Such data enclave may provide providers of services and suppliers with access to such individually identifiable patient data but only with respect to items and services furnished by such provider or supplier to such patient.

''(III) Access to data in the enclave shall not be provided to any entity unless the qualified entity and the entity have entered into a data use agreement, the terms of which contain

the requirements of this paragraph and such other terms the Secretary may specify.

''(G) ANNUAL REPORTS.—Any qualified entity that provides or sells analyses pursuant to subparagraph (A)(ii) or provides access to a qualified data enclave pursuant to subparagraph (A)(iii) shall annually submit to the Secretary a report that includes—

''(i) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

''(ii) a description of the topics and purposes of such analyses;

''(iii) information on the entities who obtained access to the qualified data enclave, the uses of the data, and the total amount of fees received for providing such access; and

''(iv) other information determined appropriate by the Secretary.''.

(b) EXPANSION OF DATA AVAILABLE TO QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended—

(1) in the subsection heading, by striking ''Medicare''; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: ''Effective July 1, 2014, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.''; and

(B) in the last sentence, by inserting ''or under titles XIX or XXI'' before the period at the end.

(c) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)) is amended by adding at the end the following new clause:

''(vi) ACCESS TO MEDICARE DATA TO FACILITATE QUALITY IMPROVEMENT.—

''(I) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, and subject to other requirements as the Secretary may specify, beginning July 1, 2014, the Secretary shall, if requested by a qualified clinical data registry under this subparagraph, subject to subclauses (II) and (III), provide data as described in section 1874(e)(3) (in a form and manner determined to be appropriate) to such registry for purposes of linking such data with clinical data and performing analyses and research to support quality improvement or patient safety.

''(II) PROTECTION.—A qualified clinical data registry may not publicly report any data made available under subclause (I) (or any analyses or research described in such subclause) that individually identifies a provider of services, supplier, or individual un-

less the registry obtains the consent of such provider, supplier, or individual prior to such reporting.

''(III) FEE.—The data described in subclause (I) shall be made available to qualified clinical data registries at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.''.

(d) REVISION OF PLACEMENT OF FEES.—Section 1874(e)(4)(A) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(A)) is amended, in the second sentence—

(1) by inserting '', for periods prior to July 1, 2014,'' after ''deposited''; and

(2) by inserting the following before the period at the end: '', and, beginning July 1, 2014, into the Centers for Medicare & Medicaid Services Program Management Account''.

SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.

(a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-OUT TO PRIVATE CONTRACT.—

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

(A) IN GENERAL.—Section 1802(b)(3) of the Social Security Act (42 U.S.C. 1395a(b)(3)) is amended—

(i) in subparagraph (B)(ii), by striking ''during the 2-year period beginning on the date the affidavit is signed'' and inserting ''during the applicable 2-year period (as defined in subparagraph (D))'';

(ii) in subparagraph (C), by striking ''during the 2-year period described in subparagraph (B)(ii)'' and inserting ''during the applicable 2-year period''; and

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

''(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the af-

fidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.''.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act.

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a(b)) is amended—

(A) in paragraph (5), by adding at the end the following new subparagraph:

''(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).'';

(B) by redesignating paragraph (5) as paragraph (6); and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

''(A) IN GENERAL.—Beginning not later than February 1, 2015, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

''(B) INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

''(i) Their number.

''(ii) Their physician or professional specialty or other designation.

''(iii) Their geographic distribution.

''(iv) The timing of their becoming opt-out physicians and practitioners, relative to when they first entered practice and with respect to applicable 2-year periods.

''(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.''.

(b) MEDICARE NON-PARTICIPATING PHYSICIANS DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish and implement a demonstration project (in this section referred to as the ''demonstration project'') under title XVIII of the Social Security Act to provide that payments for services under such title furnished by non-participating physicians (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))) to individuals entitled to benefits under part A or enrolled under part B of such title are paid directly to such physicians. The Secretary shall carry out the demonstration project in a geographic area that is a statistically significant area no larger than a State.

(2) ADVANCE NOTICE TO PHYSICIANS.—The Secretary shall, in a timely manner and prior to the beginning of the year in which payment will be made under the demonstration project, notify physicians in the geographic area described in paragraph (1) of the option to participate in the demonstration project.

(3) TIMETABLE FOR IMPLEMENTATION.—

(A) DEMONSTRATION START DATE.—The demonstration project shall apply with respect to services furnished beginning on January 1, 2015.

(B) 1-YEAR DURATION.—The Secretary shall implement the demonstration project such that payments are made under such demonstration project for a period of 1 year.

(4) REPORT.—Not later than 18 months after the date of the conclusion of the demonstration project, the Secretary shall submit to Congress a report analyzing the impact of the demonstration project. Such report shall include an analysis of the impact, if any, of the demonstration project upon the—

(A) percentage and number of physicians who choose not to participate under title XVIII

of the Social Security Act and a comparison of such percentage and number to the previous year;

(B) percentage of claims submitted by and payments made to physicians in the demonstration that are unassigned and a comparison of unassigned claims and payments by non-participating physicians in the previous year;

(C) percentage and number of the physicians in the demonstration by specialty designation; and

(D) access to services for which payment is made under such title for individuals entitled to benefits under part A or enrolled under part B of such title.

(5) BENEFICIARY NOTICE.—

(A) NOTICE BY SECRETARY TO BENEFICIARIES.—The Secretary shall notify individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act in the geographic area in which the demonstration project is conducted of the implications of physician participation in the demonstration project.

(B) NOTICE BY PHYSICIANS TO PATIENTS.—A physician who elects to participate in the demonstration project shall notify individuals to whom the physician furnishes services for which payment will be provided under the demonstration project of such election. Such notification shall be provided prior to the provision of service and include a notification, with respect to each such individual, that—

(i) the right of the individual to payment is being reassigned to the physician;

(ii) payment for services furnished by the physician to such individual will be made directly to the physician; and

(iii) the individual is responsible for the remaining amount, which may be higher than would be the case if the physician participated in the Medicare program.

(c) GAINSHARING STUDY AND REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with legislative recommendations to amend existing fraud and abuse laws, through exceptions, safe harbors,

or other narrowly targeted provisions, to permit gainsharing or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships; and

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program under title XVIII of the Social Security Act.

(d) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORD SYSTEMS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare EHR incentive programs, Congress declares it a national objective to achieve

widespread and nationwide exchange of health information through interoperable certified EHR technology by December 31, 2019.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term ''widespread interoperability'' means nationwide interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare EHR incentive programs and other clinicians and health care providers.

(ii) INTEROPERABILITY.—The term ''interoperability'' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than December 31, 2015, and in consultation with stakeholders, the Secretary shall es-

tablish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2017, then the Secretary shall submit to Congress a report, by not later than December 31, 2018, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before

the period at the end the following: ", and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation similar to that required in the health information technology donation safe harbor established under regulations under section 1128B(b)(3)(E)) that the professional has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology".

(B) FOR MEANINGFUL EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: ", and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation referred to in section 1848(o)(2)(A)(ii)) that the hospital has not and will not take any deliberate action to limit or restrict the use, compatibility, or interoperability of the certified EHR technology".

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is 6 months after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A WEBSITE TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing a website (in this subsection referred to as the ''website'') that includes aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products. Such information may be made available through contracts with physician, hospital, or other organizations that maintain such comparative information.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the website. The report shall include information on the benefits and resources of such a website.

(4) DEFINITIONS.—In this subsection:

(A) The term ''certified EHR technology'' has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term ''meaningful EHR hospital'' means an eligible hospital (as defined in section 1886(n)(6)(A) of the Social Security Act (42 U.S.C. 1395ww(n)(6)(A)) that is a meaningful EHR user.

(C) The term ''meaningful EHR professional'' means an eligible professional (as defined in section 1848(o)(5)(C) of the Social Security Act (42 U.S.C. 1395w–4(o)(5)(C)) who is a meaningful EHR user.

(D) The term ''meaningful EHR user'' has the meaning given such term under the Medicare EHR incentive programs.

(E) The term ''Medicare EHR incentive programs'' means the incentive programs under section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395w–4(o), 1395w–23, 1395ww(n)).

(F) The term ''Secretary'' means the Secretary of Health and Human Services.

(e) GAO STUDY AND REPORT ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and federal efforts can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services conducts oversight of payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under

paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

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

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

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

(A) The term ''Federal health care provision'' means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I and subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and titles XVIII and XIX of the Social Security Act.

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

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

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

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

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

(3) NO PREEMPTION.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title III of the Health Care and Education Reconciliation Act of

2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.