

[Discussion Draft]

113TH CONGRESS
1ST SESSION

H. R. _____

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

IN THE HOUSE OF REPRESENTATIVES

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

A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “_____ Act of 2013”.

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

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

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

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

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

8 (A) in subsection (d)—

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

12 (ii) in paragraph (4)—

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

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

20 (B) in subsection (f)—

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

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

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

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

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

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

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

21 “(16) UPDATE BEGINNING WITH 2019.—

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

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

9 (B) in subsection (i)(1)—

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

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

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

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

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

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

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

3 (B) in subsection (k)(2)—

4 (i) in subparagraph (C)—

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

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

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

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

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

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

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

10 (C) in subsection (k)(3)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 “(I) Clinical care.

25 “(II) Safety.

1 “(III) Care coordination.

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

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

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

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

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

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

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

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

1 “(E) CORE MEASURE SETS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(G) PERIODIC REVIEW AND UPDATES.—

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

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

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

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

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

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

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

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

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

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

18 “(iv) TRANSPARENCY.—

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

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

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

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

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

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

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

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

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

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

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

9 “(q) QUALITY UPDATE INCENTIVE PROGRAM.—

10 “(1) ESTABLISHMENT.—

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

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

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

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

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

8 “(B) DEFINITIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 “(5) FEEDBACK.—

9 “(A) FEEDBACK.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (4) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 “(1) RECOMMENDATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 or

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

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

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

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

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

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

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

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

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

13 “(2) MODELS REQUIRING WAIVER APPROVAL.—

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

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

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

5 “(e) DEMONSTRATION.—

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

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

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

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

15 “(4) REPORTING AND EVALUATION.—

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

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

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

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

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

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

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

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

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

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

18 “(ii) recommendations on—

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

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

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

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

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

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

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

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

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

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

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

10 “(7) FUNDING.—

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

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

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

1 demonstration program under this sub-
2 section that—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(g) PERIODIC REVIEW AND TERMINATION.—

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

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

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

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

11 “(2) TERMINATION.—

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

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

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

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

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

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

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

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

11 (2) DEFINITIONS.—In this subsection:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **SEC. 5. MISCELLANEOUS.**

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

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

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

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

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

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

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

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

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

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

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

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

22 (B) GAO AND MEDPAC REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (dd) Gainsharing arrange-
11 ments

12 (II) ITEMS TO BE INCLUDED.—
13 Such report shall include information
14 on how each recommended new pay-
15 ment model will achieve maximum
16 flexibility to reward high quality, effi-
17 cient care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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