

**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:

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

2 (a) SHORT TITLE.—This Act may be cited as the
3 “SGR Repeal and Medicare Beneficiary Access Act of
4 2013”.

5 (b) TABLE OF CONTENTS.—The table of contents for
6 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.

**7 SEC. 2. REPEALING THE SUSTAINABLE GROWTH RATE
8 (SGR) AND IMPROVING MEDICARE PAYMENT
9 FOR PHYSICIANS’ SERVICES.**

10 (a) STABILIZING FEE UPDATES.—

1 (1) REPEAL OF SGR PAYMENT METHOD-
2 OLOGY.—Section 1848 of the Social Security Act
3 (42 U.S.C. 1395w–4) is amended—

4 (A) in subsection (d)—

5 (i) in paragraph (1)(A), by inserting
6 “or a subsequent paragraph” after “para-
7 graph (4)”; and

8 (ii) in paragraph (4)—

9 (I) in the heading, by inserting
10 “AND ENDING WITH 2013” after
11 “YEARS BEGINNING WITH 2001”; and

12 (II) in subparagraph (A), by in-
13 serting “and ending with 2013” after
14 “a year beginning with 2001”; and

15 (B) in subsection (f)—

16 (i) in paragraph (1)(B), by inserting
17 “through 2013” after “of each succeeding
18 year”; and

19 (ii) in paragraph (2), by inserting
20 “and ending with 2013” after “beginning
21 with 2000”.

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

1 amended by adding at the end the following new
2 paragraphs:

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

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

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

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

18 “(B) for other items and services, 1 per-
19 cent.”.

20 (3) MEDPAC REPORTS.—

21 (A) INITIAL REPORT.—Not later than July
22 1, 2016, the Medicare Payment Advisory Com-
23 mission shall submit to Congress a report on
24 the relationship between—

1 (i) physician and other health profes-
2 sional utilization and expenditures (and the
3 rate of increase of such utilization and ex-
4 penditures) of items and services for which
5 payment is made under section 1848 of the
6 Social Security Act (42 U.S.C. 1395w-4);
7 and

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

12 Such report shall include a methodology to de-
13 scribe such relationship and the impact of
14 changes in such physician and other health pro-
15 fessional practice and service ordering patterns
16 on total utilization and expenditures under
17 parts A, B, and D of such title.

18 (B) FINAL REPORT.—Not later than July
19 1, 2020, the Medicare Payment Advisory Com-
20 mission shall submit to Congress a report on
21 the relationship described in subparagraph (A),
22 including the results determined from applying
23 the methodology included in the report sub-
24 mitted under such subparagraph.

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

4 (1) EHR MEANINGFUL USE INCENTIVE PRO-
5 GRAM.—

6 (A) SUNSETTING SEPARATE MEANINGFUL
7 USE PAYMENT ADJUSTMENTS.—Section
8 1848(a)(7)(A) of the Social Security Act (42
9 U.S.C. 1395w-4(a)(7)(A)) is amended—

10 (i) in clause (i), by striking “or any
11 subsequent payment year” and inserting
12 “or 2016”;

13 (ii) in clause (ii)—

14 (I) in the matter preceding sub-
15 clause (I), by striking “Subject to
16 clause (iii), for” and inserting “For”;

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

19 (III) in subclause (II), by strik-
20 ing “; and” and inserting a period;
21 and

22 (IV) by striking subclause (III);
23 and

24 (iii) by striking clause (iii).

1 (B) CONTINUATION OF MEANINGFUL USE
2 DETERMINATIONS FOR VBP PROGRAM.—Section
3 1848(o)(2) of the Social Security Act (42
4 U.S.C. 1395w-4(o)(2)) is amended—

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

7 (I) by striking “For purposes of
8 paragraph (1), an” and inserting
9 “An”; and

10 (II) by inserting “, or pursuant
11 to subparagraph (D) for purposes of
12 subsection (q), for a performance pe-
13 riod under such subsection for a year”
14 after “under such subsection for a
15 year”; and

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

18 “(D) CONTINUED APPLICATION FOR PUR-
19 POSES OF VBP PROGRAM.—With respect to
20 2017 and each subsequent payment year, the
21 Secretary shall, for purposes of subsection (q)
22 and in accordance with paragraph (1)(F) of
23 such subsection, determine whether an eligible
24 professional who is a VBP eligible professional
25 (as defined in subsection (q)(1)(C)) for such

1 year is a meaningful EHR user under this
2 paragraph for the performance period under
3 subsection (q) for such year.”.

4 (2) QUALITY REPORTING.—

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

9 (i) in clause (i), by striking “or any
10 subsequent year” and inserting “or 2016”;
11 and

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

14 (B) CONTINUATION OF QUALITY MEAS-
15 URES AND PROCESSES FOR VBP PROGRAM.—
16 Section 1848 of the Social Security Act (42
17 U.S.C. 1395w-4) is amended—

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

20 “(9) CONTINUED APPLICATION FOR PURPOSES
21 OF VBP PROGRAM.—The Secretary shall, in accord-
22 ance with subsection (q)(1)(F), carry out the provi-
23 sions of this subsection for purposes of subsection
24 (q).”; and

25 (ii) in subsection (m)—

1 (I) by redesignating the para-
2 graph (7) added by section 10327(a)
3 of Public Law 111-148 as paragraph
4 (8); and

5 (II) by adding at the end the fol-
6 lowing new paragraph:

7 “(9) CONTINUED APPLICATION FOR PURPOSES
8 OF VBP PROGRAM.—The Secretary shall, in accord-
9 ance with subsection (q)(1)(F), carry out the proc-
10 esses under this subsection for purposes of sub-
11 section (q).”.

12 (3) VALUE-BASED PAYMENTS.—

13 (A) SUNSETTING SEPARATE VALUE-BASED
14 PAYMENTS.—Clause (iii) of section
15 1848(p)(4)(B) of the Social Security Act (42
16 U.S.C. 1395w-4(p)(4)(B)) is amended to read
17 as follows:

18 “(iii) APPLICATION.—The Secretary
19 shall apply the payment modifier estab-
20 lished under this subsection for items and
21 services furnished on or after January 1,
22 2015, but before January 1, 2017, with re-
23 spect to specific physicians and groups of
24 physicians the Secretary determines appro-
25 priate. Such payment modifier shall not be

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

3 (B) CONTINUATION OF VALUE-BASED PAY-
4 MENT MODIFIER MEASURES FOR VBP PRO-
5 GRAM.—Section 1848(p) of the Social Security
6 Act (42 U.S.C. 1395w-4(p)) is amended—

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

9 “(C) CONTINUED APPLICATION FOR PUR-
10 POSES OF VBP PROGRAM.—The Secretary shall,
11 in accordance with subsection (q)(1)(F), carry
12 out subparagraph (B) for purposes of sub-
13 section (q).” ; and

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

20 (c) VALUE-BASED PERFORMANCE INCENTIVE PRO-
21 GRAM.—

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

1 “(q) VALUE-BASED PERFORMANCE INCENTIVE PRO-
2 GRAM.—

3 “(1) ESTABLISHMENT.—

4 “(A) IN GENERAL.—Subject to the suc-
5 ceeding provisions of this subsection, the Sec-
6 retary shall establish an eligible professional
7 value-based performance incentive program (in
8 this subsection referred to as the ‘VBP pro-
9 gram’) under which the Secretary shall—

10 “(i) develop a methodology for assess-
11 ing the total performance of each VBP eli-
12 gible professional according to performance
13 standards under paragraph (3) for a per-
14 formance period (as established under
15 paragraph (4)) for a year;

16 “(ii) using such methodology, provide
17 for a composite performance score in ac-
18 cordance with paragraph (5) for each such
19 professional for each performance period;
20 and

21 “(iii) use such composite performance
22 score of the VBP eligible professional for a
23 performance period for a year to make
24 VBP program incentive payments under

1 paragraph (7) to the professional for the
2 year.

3 “(B) PROGRAM IMPLEMENTATION.—The
4 VBP program shall apply to payments for items
5 and services furnished on or after January 1,
6 2017.

7 “(C) VBP ELIGIBLE PROFESSIONAL DE-
8 FINED.—

9 “(i) IN GENERAL.—For purposes of
10 this subsection, subject to clauses (ii) and
11 (iv), the term ‘VBP eligible professional’
12 means—

13 “(I) for the first and second
14 years for which the VBP program ap-
15 plies to payments (and for the per-
16 formance period for such first and
17 second year), a physician (as defined
18 in section 1861(r)(1)), a physician as-
19 sistant, nurse practitioner, and clin-
20 ical nurse specialist (as such terms
21 are defined in section 1861(aa)(5)),
22 and a certified registered nurse anes-
23 thetist (as defined in section
24 1861(bb)(2)); and

1 “(II) for the third year for which
2 the VBP program applies to payments
3 (and for the performance period for
4 such third year) and for each suc-
5 ceeding year (and for the performance
6 period for each such year), the profes-
7 sionals described in subclause (I) and
8 such other eligible professionals (as
9 defined in subsection (k)(3)(B)) as
10 specified by the Secretary.

11 “(ii) EXCLUSIONS.—For purposes of
12 clause (i), the term ‘VBP eligible profes-
13 sional’ does not include, with respect to a
14 year, an eligible professional (as defined in
15 subsection (k)(3)(B))—

16 “(I) who is a qualifying APM
17 participant (as defined in section
18 1833(z)(2));

19 “(II) who, subject to clause (vii),
20 is a partial qualifying APM partici-
21 pant (as defined in clause (iii)) for the
22 most recent period for which data are
23 available and who, for the perform-
24 ance period with respect to such year,
25 does not report on applicable meas-

1 ures and activities described in para-
2 graph (2)(B) that are required to be
3 reported by such a professional under
4 the VBP program; or

5 “(III) who, for the performance
6 period with respect to such year, does
7 not exceed the low-volume threshold
8 measurement selected under clause
9 (iv).

10 “(iii) PARTIAL QUALIFYING APM PAR-
11 TICIPANT.—For purposes of this subpara-
12 graph, the term ‘partial qualifying APM
13 participant’ means, with respect to a year,
14 an eligible professional for whom the Sec-
15 retary determines the minimum payment
16 percentage (or percentages), as applicable,
17 described in paragraph (2) of section
18 1833(z) for such year have not been satis-
19 fied, but who would be considered a quali-
20 fying APM participant (as defined in such
21 paragraph) for such year if—

22 “(I) with respect to 2017 and
23 2018, the reference in subparagraph
24 (A) of such paragraph to 25 percent
25 was instead a reference to 20 percent;

1 “(II) with respect to 2019 and
2 2020—

3 “(aa) the reference in sub-
4 paragraph (B)(i) of such para-
5 graph to 50 percent was instead
6 a reference to 40 percent; and

7 “(bb) the references in sub-
8 paragraph (B)(ii) of such para-
9 graph to 50 percent and 25 per-
10 cent of such paragraph were in-
11 stead references to 40 percent
12 and 20 percent, respectively; and

13 “(III) with respect to 2021 and
14 subsequent years—

15 “(aa) the reference in sub-
16 paragraph (C)(i) of such para-
17 graph to 75 percent was instead
18 a reference to 50 percent; and

19 “(bb) the references in sub-
20 paragraph (C)(ii) of such para-
21 graph to 75 percent and 25 per-
22 cent of such paragraph were in-
23 stead references to 50 percent
24 and 20 percent, respectively.

1 “(iv) SELECTION OF LOW-VOLUME
2 THRESHOLD MEASUREMENT.—The Sec-
3 retary shall select one of the following low-
4 volume threshold measurements to apply
5 for purposes of clause (ii)(III):

6 “(I) The minimum number (as
7 determined by the Secretary) of indi-
8 viduals enrolled under this part who
9 are treated by the VBP eligible pro-
10 fessional for the performance period
11 involved.

12 “(II) The minimum number (as
13 determined by the Secretary) of items
14 and services furnished to individuals
15 enrolled under this part by such pro-
16 fessional for such performance period.

17 “(III) The minimum amount (as
18 determined by the Secretary) of al-
19 lowed charges billed by such profes-
20 sional under this part for such per-
21 formance period.

22 “(v) TREATMENT OF NEW MEDICARE
23 ENROLLED ELIGIBLE PROFESSIONALS.—In
24 the case of a professional who first be-
25 comes a Medicare enrolled eligible profes-

1 sional during the performance period for a
2 year (and had not previously submitted
3 claims under this title such as a person, an
4 entity, or a part of a physician group or
5 under a different billing number or tax
6 identifier), such professional shall not be
7 treated under this subsection as a VBP eli-
8 gible professional until the subsequent year
9 and performance period for such subse-
10 quent year.

11 “(vi) CLARIFICATION.—In the case of
12 items and services furnished during a year
13 by an individual who is not a VBP eligible
14 professional (including pursuant to clauses
15 (ii) and (v)) with respect to a year, in no
16 case shall a reduction under paragraph (6)
17 or a VBP program incentive payment
18 under paragraph (7) apply to such indi-
19 vidual for such year.

20 “(vii) PARTIAL QUALIFYING APM PAR-
21 TICIPANT CLARIFICATION.—In the case of
22 an eligible professional who is a partial
23 qualifying APM participant, with respect
24 to a year, and who for the performance pe-
25 riod for such year reports on applicable

1 measures and activities described in para-
2 graph (2)(B) that are required to be re-
3 ported by such a professional under the
4 VBP program, such eligible professional is
5 considered to be a VBP eligible profes-
6 sional with respect to such year.

7 “(D) APPLICATION TO GROUP PRAC-
8 TICES.—

9 “(i) IN GENERAL.—Under the VBP
10 program:

11 “(I) QUALITY PERFORMANCE
12 CATEGORY.—The Secretary shall es-
13 tablish and apply a process that in-
14 cludes features of the provisions of
15 subsection (m)(3)(C) for VBP eligible
16 professionals in a group practice with
17 respect to assessing performance of
18 such group with respect to the per-
19 formance category described in clause
20 (i) of paragraph (2)(A).

21 “(II) OTHER PERFORMANCE CAT-
22 EGORIES.—The Secretary may estab-
23 lish and apply a process that includes
24 features of the provisions of sub-
25 section (m)(3)(C) for VBP eligible

1 professionals in a group practice with
2 respect to assessing the performance
3 of such group with respect to the per-
4 formance categories described in
5 clauses (ii) through (iv) of such para-
6 graph.

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

14 “(iii) CLARIFICATION.—VBP eligible
15 professionals electing to be a virtual group
16 under paragraph (5)(J) shall not be con-
17 sidered VBP eligible professionals in a
18 group practice for purposes of applying
19 this subparagraph.

20 “(E) USE OF REGISTRIES.—Under the
21 VBP program, the Secretary shall encourage
22 the use of qualified clinical data registries pur-
23 suant to subsection (m)(3)(E) in carrying out
24 this subsection.

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

5 “(i) adjust the application of such
6 provision to ensure the provision is con-
7 sistent with the provisions of this sub-
8 section; and

9 “(ii) not apply such provision to the
10 extent that the provision is duplicative with
11 a provision of this subsection.

12 “(2) MEASURES AND ACTIVITIES UNDER PER-
13 FORMANCE CATEGORIES.—

14 “(A) PERFORMANCE CATEGORIES.—Under
15 the VBP program, the Secretary shall use the
16 following performance categories (each of which
17 is referred to in this subsection as a perform-
18 ance category) in determining the composite
19 performance score under paragraph (5):

20 “(i) Quality.

21 “(ii) Resource use.

22 “(iii) Clinical practice improvement
23 activities.

24 “(iv) Meaningful use of certified EHR
25 technology.

1 “(B) MEASURES AND ACTIVITIES SPECI-
2 FIED FOR EACH CATEGORY.—For purposes of
3 paragraph (3)(A) and subject to subparagraph
4 (C), measures and activities specified for a per-
5 formance period (as established under para-
6 graph (4)) for a year are as follows:

7 “(i) QUALITY.—For the performance
8 category described in subparagraph (A)(i),
9 the quality measures established for such
10 period under subsections (k) and (m), in-
11 cluding under subsection (m)(3)(E), and
12 the measures of quality of care established
13 for such period under subsection (p)(2).

14 “(ii) RESOURCE USE.—For the per-
15 formance category described in subpara-
16 graph (A)(ii), the measurement of resource
17 use for such period under subsection
18 (p)(3), using the methodology under sub-
19 section (r), as appropriate, and, as feasible
20 and applicable, accounting for the cost of
21 covered part D drugs.

22 “(iii) CLINICAL PRACTICE IMPROVE-
23 MENT ACTIVITIES.—For the performance
24 category described in subparagraph
25 (A)(iii), clinical practice improvement ac-

1 activities under subcategories specified by the
2 Secretary for such period, which shall in-
3 clude at least the following:

4 “(I) The subcategory of expanded
5 practice access, which shall include ac-
6 tivities such as same day appoint-
7 ments for urgent needs and after
8 hours access to clinician advice.

9 “(II) The subcategory of popu-
10 lation management, which shall in-
11 clude activities such as monitoring
12 health conditions of individuals to pro-
13 vide timely health care interventions
14 or participation in a qualified clinical
15 data registry.

16 “(III) The subcategory of care
17 coordination, which shall include ac-
18 tivities such as timely communication
19 of test results, timely exchange of
20 clinical information to patients and
21 other providers, and use of remote
22 monitoring or telehealth.

23 “(IV) The subcategory of bene-
24 ficiary engagement, which shall in-
25 clude activities such as the establish-

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

5 “(V) The subcategory of patient
6 safety and practice assessment, such
7 as through use of clinical or surgical
8 checklists and practice assessments
9 related to maintaining certification.

10 “(VI) The subcategory of partici-
11 pation in an alternative payment
12 model (as defined in section
13 1833(z)(3)(C)).

14 In establishing activities under this clause,
15 the Secretary shall give consideration to
16 the circumstances of small practices (con-
17 sisting of fewer than 20 professionals) and
18 practices located in rural areas and in
19 health professional shortage areas (as des-
20 ignated under section 332(a)(1)(A) of the
21 Public Health Service Act).

22 “(iv) MEANINGFUL EHR USE.—For
23 the performance category described in sub-
24 paragraph (A)(iv), the requirements estab-
25 lished for such period under subsection

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

3 “(C) ADDITIONAL PROVISIONS.—

4 “(i) EMPHASIZING OUTCOME MEAS-
5 URES UNDER QUALITY PERFORMANCE CAT-
6 EGORY.—In applying subparagraph (B)(i),
7 the Secretary shall, as feasible, emphasize
8 the application of outcome measures.

9 “(ii) APPLICATION OF ADDITIONAL
10 SYSTEM MEASURES.—The Secretary may
11 use measures used for a payment system
12 other than for physicians for purposes of
13 the performance category described in sub-
14 paragraph (A)(i).

15 “(iii) GLOBAL AND POPULATION-
16 BASED MEASURES.—The Secretary may
17 use global measures, such as global out-
18 come measures, and population-based
19 measures for purposes of the performance
20 category described in subparagraph (A)(i).

21 “(iv) REQUEST FOR INFORMATION
22 FOR CLINICAL PRACTICE IMPROVEMENT
23 ACTIVITIES.—In initially applying subpara-
24 graph (B)(iii), the Secretary shall use a re-
25 quest for information to solicit rec-

1 ommendations from stakeholders for iden-
2 tifying activities described in such subpara-
3 graph and specifying criteria for such ac-
4 tivities.

5 “(v) CONTRACT AUTHORITY FOR
6 CLINICAL PRACTICE IMPROVEMENT ACTIVI-
7 TIES PERFORMANCE CATEGORY.—In apply-
8 ing subparagraph (B)(iii), the Secretary
9 may contract with entities to assist the
10 Secretary in—

11 “(I) identifying activities de-
12 scribed in subparagraph (B)(iii);

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

15 “(III) determining whether a
16 VBP eligible professional meets such
17 criteria.

18 “(vi) APPLICATION OF MEASURES AND
19 ACTIVITIES TO NON-PATIENT-FACING PRO-
20 VIDERS.—In carrying out this paragraph,
21 with respect to measures and activities
22 specified in subparagraph (B) for perform-
23 ance categories described in subparagraph
24 (A), the Secretary—

1 “(I) shall give consideration to
2 the circumstances of professional
3 types (or subcategories of those types
4 determined by practice characteris-
5 tics) who typically provide services
6 that do not involve face-to-face inter-
7 action with a patient; and

8 “(II) may, to the extent feasible
9 and appropriate, take into account
10 such circumstances and apply under
11 this subsection with respect to VBP
12 eligible professionals of such profes-
13 sional types or subcategories, in lieu
14 of such a measure or activity, a com-
15 parable measure or activity that ful-
16 fills the goals of the applicable per-
17 formance category.

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

21 “(3) PERFORMANCE STANDARDS.—

22 “(A) ESTABLISHMENT.—Under the VBP
23 program, the Secretary shall establish perform-
24 ance standards with respect to measures and
25 activities specified under paragraph (2)(B) for

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

3 “(B) CONSIDERATIONS IN ESTABLISHING
4 STANDARDS.—In establishing such performance
5 standards with respect to measures and activi-
6 ties specified under paragraph (2)(B), the Sec-
7 retary shall take into account the following:

8 “(i) Historical performance standards.

9 “(ii) Improvement rates.

10 “(iii) The opportunity for continued
11 improvement.

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

21 “(5) COMPOSITE PERFORMANCE SCORE.—

22 “(A) IN GENERAL.—Subject to the suc-
23 ceeding provisions of this paragraph and con-
24 sistent with section 2(g)(2) of the SGR Repeal
25 and Medicare Beneficiary Access Act of 2013,

1 the Secretary shall develop a methodology for
2 assessing the total performance of each VBP el-
3 igible professional according to performance
4 standards under paragraph (3) with respect to
5 applicable measures and activities specified in
6 paragraph (2)(B) with respect to each perform-
7 ance category applicable to such professional
8 for a performance period (as established under
9 paragraph (4)) for a year. Using such method-
10 ology, the Secretary shall provide for a com-
11 posite assessment (in this subsection referred to
12 as the ‘composite performance score’) for each
13 such professional for each performance period.

14 “(B) WEIGHTING PERFORMANCE CAT-
15 EGORIES, MEASURES, AND ACTIVITIES.—Under
16 the methodology under subparagraph (A), the
17 Secretary—

18 “(i) may assign different scoring
19 weights (including a weight of 0) for—

20 “(I) each performance category
21 based on the extent to which the cat-
22 egory is applicable to the type of eligi-
23 ble professional involved; and

24 “(II) each measure and activity
25 specified under paragraph (2)(B) with

1 respect to each such category based
2 on the extent to which the measure or
3 activity is applicable to the type of eli-
4 gible professional involved; and

5 “(ii) with respect to the performance
6 category described in paragraph
7 (2)(A)(i)—

8 “(I) shall assign a higher scoring
9 weight to outcomes measures than to
10 other measures and increase the scor-
11 ing weight for outcome measures over
12 time; and

13 “(II) may assign a higher scoring
14 weight to patient experience measures.

15 “(C) INCENTIVE TO REPORT; ENCOUR-
16 AGING USE OF CERTIFIED EHR TECHNOLOGY
17 FOR REPORTING QUALITY MEASURES.—

18 “(i) INCENTIVE TO REPORT.—Under
19 the methodology established under sub-
20 paragraph (A), the Secretary shall provide
21 that in the case of a VBP eligible profes-
22 sional who fails to report on an applicable
23 measure or activity that is required to be
24 reported by the professional, the profes-
25 sional shall be treated as achieving the

1 lowest potential score applicable to such
2 measure or activity.

3 “(ii) ENCOURAGING USE OF CER-
4 TIFIED EHR TECHNOLOGY FOR REPORTING
5 QUALITY MEASURES.—Under the method-
6 ology established under subparagraph (A),
7 the Secretary shall—

8 “(I) encourage VBP eligible pro-
9 fessionals to report on applicable
10 measures with respect to the perform-
11 ance category described in paragraph
12 (2)(A)(i) through the use of certified
13 EHR technology; and

14 “(II) with respect to a perform-
15 ance period, with respect to a year,
16 for which a VBP eligible professional
17 reports such measures through the
18 use of such EHR technology, treat
19 such professional as satisfying the
20 clinical quality measures reporting re-
21 quirement described in subsection
22 (o)(2)(A)(iii) for such year.

23 “(D) CLINICAL PRACTICE IMPROVEMENT
24 ACTIVITIES PERFORMANCE SCORE.—

1 “(i) RULE FOR ACCREDITATION.—A
2 VBP eligible professional who is in a prac-
3 tice that is certified as a patient-centered
4 medical home or comparable specialty
5 practice pursuant to subsection
6 (b)(8)(B)(i) with respect to a performance
7 period shall be given the highest potential
8 score for the performance category de-
9 scribed in paragraph (2)(A)(iii) for such
10 period.

11 “(ii) APM PARTICIPATION.—Partici-
12 pation by a VBP eligible professional in an
13 alternative payment model (as defined in
14 section 1833(z)(3)(C)) with respect to a
15 performance period shall earn such eligible
16 professional one-half of the highest poten-
17 tial score for the performance category de-
18 scribed in paragraph (2)(A)(iii) for such
19 performance period. Nothing in the pre-
20 vious sentence shall prevent such profes-
21 sional from earning more than one-half of
22 such highest potential score for such per-
23 formance period by performing additional
24 activities with respect to such performance
25 category.

1 “(iii) SUBCATEGORIES.—A VBP eligi-
2 ble professional shall not be required to
3 perform activities in each subcategory
4 under paragraph (2)(B)(iii) to achieve the
5 highest potential score for the performance
6 category described in paragraph (2)(A)(iii).

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

13 “(F) ACHIEVEMENT AND IMPROVEMENT.—

14 “(i) TAKING INTO ACCOUNT IMPROVE-
15 MENT.—Beginning with the second year to
16 which the VBP program applies, in addi-
17 tion to the achievement score of a VBP eli-
18 gible professional, the methodology devel-
19 oped under subparagraph (A)—

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

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

5 “(ii) ASSIGNING HIGHER WEIGHT FOR
6 ACHIEVEMENT.—Beginning with the
7 fourth year to which the VBP program ap-
8 plies, under the methodology developed
9 under subparagraph (A), the Secretary
10 may assign a higher scoring weight under
11 subparagraph (B) with respect to the
12 achievement score of a VBP eligible profes-
13 sional with respect to a measure or activity
14 specified under paragraph (2)(B) (or with
15 respect to such a measure or activity and
16 with respect to categories described in
17 paragraph (2)(A)) than to any improve-
18 ment score applied under clause (i) with
19 respect to such measure or activity (or
20 such measure or activity and categories).

21 “(G) WEIGHTS FOR THE PERFORMANCE
22 CATEGORIES.—

23 “(i) IN GENERAL.—Under the meth-
24 odology developed under subparagraph (A),
25 subject to clauses (ii) and (iii), the com-

1 positive performance score shall be deter-
2 mined as follows:

3 “(I) QUALITY.—Thirty percent of
4 such score shall be based on perform-
5 ance with respect to the category de-
6 scribed in clause (i) of paragraph
7 (2)(A).

8 “(II) RESOURCE USE.—

9 “(aa) IN GENERAL.—Sub-
10 ject to item (bb), thirty percent
11 of such score shall be based on
12 performance with respect to the
13 category described in clause (ii)
14 of paragraph (2)(A).

15 “(bb) FIRST 2 YEARS AND
16 TEST YEAR.—For the for the
17 first and second years for which
18 the VBP program applies to pay-
19 ments, zero percent of such score
20 shall be based on performance
21 with respect to the category de-
22 scribed in clause (ii) of para-
23 graph (2)(A). With respect to the
24 subsequent year, the percent de-
25 scribed in item (aa) of such score

1 shall be based on performance
2 with respect to such category
3 only for purposes of feedback and
4 zero percent of such score shall
5 be based on performance with re-
6 spect to such category for any
7 other purpose under this sub-
8 section.

9 “(III) CLINICAL PRACTICE IM-
10 PROVEMENT ACTIVITIES.—Fifteen
11 percent of such score shall be based
12 on performance with respect to the
13 category described in clause (iii) of
14 paragraph (2)(A).

15 “(IV) MEANINGFUL USE OF CER-
16 TIFIED EHR TECHNOLOGY.—Twenty-
17 five percent of such score shall be
18 based on performance with respect to
19 the category described in clause (iv) of
20 paragraph (2)(A).

21 “(ii) AUTHORITY TO ADJUST PER-
22 CENTAGES IN CASE OF HIGH EHR MEAN-
23 INGFUL USE ADOPTION.—In any year in
24 which the Secretary estimates that the pro-
25 portion of eligible professionals (as defined

1 in subsection (o)(5)) who are meaningful
2 EHR users (as determined under sub-
3 section (o)(2)) is 75 percent or greater, the
4 Secretary may reduce the percent applica-
5 ble under clause (i)(IV), but not below 15
6 percent. If the Secretary makes such re-
7 duction for a year, the percentages applica-
8 ble under one or more of subclauses (I),
9 (II), and (III) of clause (i) for such year
10 shall be increased in a manner such that
11 the total percentage points of the increase
12 under this clause for such year equals the
13 total number of percentage points reduced
14 under the preceding sentence for such
15 year.

16 “(iii) AUTHORITY TO ADJUST PER-
17 CENTAGES FOR QUALITY AND RESOURCE
18 USE.—The percentages described in sub-
19 clauses (I) and (II) of clause (i), including
20 after application of clause (ii), shall be
21 equal.

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

1 ology described in subsection (r)(5), as appro-
2 priate.

3 “(I) INCLUSION OF QUALITY MEASURE
4 DATA FROM MULTIPLE PAYERS.—In applying
5 subsections (k), (m), and (p) with respect to
6 measures described in paragraph (2)(B)(i),
7 analysis of the performance category described
8 in paragraph (2)(A)(i) may include data sub-
9 mitted by VBP eligible professionals with re-
10 spect to multiple payers.

11 “(J) USE OF VOLUNTARY VIRTUAL
12 GROUPS FOR CERTAIN ASSESSMENT PUR-
13 POSES.—

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

20 “(I) the assessment of perform-
21 ance provided under such methodology
22 with respect to the performance cat-
23 egories described in clauses (i) and
24 (ii) of paragraph (2)(A) that is to be
25 applied to each such professional in

1 such group for such performance pe-
2 riod shall be with respect to the com-
3 bined performance of all such profes-
4 sionals in such group for such period;
5 and

6 “(II) the composite score pro-
7 vided under this paragraph for such
8 performance period with respect to
9 each such performance category for
10 each such VBP eligible professional in
11 such virtual group shall be based on
12 the assessment of the combined per-
13 formance under subclause (I) for the
14 performance category and perform-
15 ance period.

16 “(ii) ELECTION OF PRACTICES TO BE
17 A VIRTUAL GROUP.—The Secretary shall,
18 in accordance with clause (iii), establish
19 and have in place a process to allow an in-
20 dividual VBP eligible professional or a
21 group practice consisting of not more than
22 10 VBP eligible professionals to elect, with
23 respect to a performance period for a year,
24 for such individual VBP eligible profes-
25 sional or all such VBP eligible profes-

1 sionals in such group practice, respectively,
2 to be a virtual group under this subpara-
3 graph with at least one other such indi-
4 vidual VBP eligible professional or group
5 practice making such an election.

6 “(iii) REQUIREMENTS.—The process
7 under clause (ii) shall provide that—

8 “(I) an election under such
9 clause, with respect to a performance
10 period, shall be made before the be-
11 ginning of such performance period
12 and may not be changed during such
13 performance period; and

14 “(II) a practice described in such
15 clause, and each VBP eligible profes-
16 sional in such practice, may elect to
17 be in no more than one virtual group
18 for a performance period.

19 “(6) FUNDING FOR VBP PROGRAM INCENTIVE
20 PAYMENTS.—

21 “(A) TOTAL AMOUNT FOR INCENTIVE PAY-
22 MENTS.—The total amount for VBP program
23 incentive payments under paragraph (7) for all
24 VBP eligible professionals for a year shall be
25 equal to the total amount of the performance

1 funding pool for all VBP eligible professionals
2 under subparagraph (B) for such year, as esti-
3 mated by the Secretary.

4 “(B) PERFORMANCE FUNDING POOL.—

5 “(i) IN GENERAL.—In the case of
6 items and services furnished by a VBP eli-
7 gible professional during a year (beginning
8 with 2017), the otherwise applicable fee
9 schedule amount (as defined in clause (iii))
10 with respect to such items and services and
11 eligible professional for such year shall be
12 reduced by the applicable percent under
13 clause (ii). The total amount of such re-
14 ductions for a year shall be referred to in
15 this subsection as the ‘performance fund-
16 ing pool’ for such year.

17 “(ii) APPLICABLE PERCENT DE-
18 FINED.—For purposes of clause (i), the
19 term ‘applicable percent’ means—

20 “(I) for 2017, 4 percent;

21 “(II) for 2018, 6 percent;

22 “(III) for 2019, 8 percent;

23 “(IV) for 2020, 10 percent; and

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

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

3 “(iii) OTHERWISE APPLICABLE FEE
4 SCHEDULE AMOUNT.—For purposes of this
5 subparagraph and paragraph (7), the term
6 ‘otherwise applicable fee schedule amount’
7 means, with respect to items and services
8 furnished by a VBP eligible professional
9 during a year, the fee schedule amount for
10 such items and services and year that
11 would otherwise apply (without application
12 of this subparagraph or paragraph (7))
13 with respect to such eligible professional
14 under subsection (b), after application of
15 subsection (a)(3), or under another fee
16 schedule under this part.

17 “(7) VBP PROGRAM INCENTIVE PAYMENTS.—

18 “(A) VBP PROGRAM INCENTIVE PAYMENT
19 ADJUSTMENT FACTOR.—Consistent with section
20 2(g)(2) of the SGR Repeal and Medicare Bene-
21 ficiary Access Act of 2013, the Secretary shall
22 specify a VBP program incentive payment ad-
23 justment factor for each VBP eligible profes-
24 sional for a year. Such VBP program incentive

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

3 “(i) by the composite performance
4 score of the eligible professional for such
5 year;

6 “(ii) in a manner such that the ad-
7 justment factors specified under this sub-
8 paragraph for a year results in differential
9 payments under this paragraph reflecting
10 the full range of the distribution of com-
11 posite performance scores of VBP eligible
12 professionals determined under paragraph
13 (5)(E) for such year, with such profes-
14 sionals having higher composite perform-
15 ance scores receiving higher payment; and

16 “(iii) in a manner such that the ad-
17 justment factors specified under this sub-
18 paragraph for a year—

19 “(I) does not result in a payment
20 reduction for such year by an amount
21 that exceeds the applicable percent de-
22 scribed in paragraph (6)(B)(ii) for
23 such year; and

24 “(II) does not result in a pay-
25 ment increase for such year by an

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

4 “(B) CALCULATION OF VBP PROGRAM IN-
5 CENTIVE PAYMENT AMOUNTS.—The VBP pro-
6 gram incentive payment amount with respect to
7 items and services furnished by a VBP eligible
8 professional during a year shall be equal to the
9 difference between—

10 “(i) the product of—

11 “(I) the VBP program incentive
12 payment adjustment factor deter-
13 mined under subparagraph (A) for
14 such VBP eligible professional for
15 such year; and

16 “(II) the otherwise applicable fee
17 schedule amount (as defined in para-
18 graph (6)(B)(iii)) with respect to such
19 items and services and eligible profes-
20 sional for such year; and

21 “(ii) the otherwise applicable fee
22 schedule amount, as reduced under para-
23 graph (6)(B), with respect to such items
24 and services, eligible professional, and
25 year.

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

5 “(C) APPLICATION OF VBP PROGRAM IN-
6 CENTIVE PAYMENT AMOUNT.—In the case of
7 items and services furnished by a VBP eligible
8 professional during a year (beginning with
9 2017), the otherwise applicable fee schedule
10 amount, as reduced under paragraph (6)(B),
11 with respect to such items and services and eli-
12 gible professional for such year shall be in-
13 creased, if applicable, by the VBP program in-
14 centive payment amount determined under sub-
15 paragraph (B) with respect to such items and
16 services, professional, and year.

17 “(D) BUDGET NEUTRALITY.—In specifying
18 the VBP program incentive payment adjust-
19 ment factor for each VBP eligible professional
20 for a year under subparagraph (A), the Sec-
21 retary shall ensure that the total amount of
22 VBP program incentive payment amounts
23 under this paragraph for all VBP eligible pro-
24 fessionals in a year shall be equal to the per-

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

3 “(8) ANNOUNCEMENT OF RESULT OF ADJUST-
4 MENTS.—Under the VBP program, the Secretary
5 shall, not later than 60 days prior to the year in-
6 volved, make available to each VBP eligible profes-
7 sional the VBP program incentive payment adjust-
8 ment factor under paragraph (7) and the payment
9 reduction under paragraph (6) applicable to the eli-
10 gible professional for items and services furnished by
11 the professional in such year. The Secretary may in-
12 clude such information in the confidential feedback
13 under paragraph (13).

14 “(9) NO EFFECT IN SUBSEQUENT YEARS.—The
15 VBP program incentive payment under paragraph
16 (7) and the payment reduction under paragraph (6)
17 shall each apply only with respect to the year in-
18 volved, and the Secretary shall not take into account
19 such VBP program incentive payment or payment
20 reduction in making payments to a VBP eligible pro-
21 fessional under this part in a subsequent year.

22 “(10) PUBLIC REPORTING.—

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

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

3 “(i) Information regarding the per-
4 formance of VBP eligible professionals
5 under the VBP program, which—

6 “(I) shall include the composite
7 score for each such VBP eligible pro-
8 fessional and the performance of each
9 such VBP eligible professional with
10 respect to each performance category;
11 and

12 “(II) may include the perform-
13 ance of each such VBP eligible profes-
14 sional with respect to each measure or
15 activity specified in paragraph (2)(B).

16 “(ii) The names of eligible profes-
17 sionals in eligible alternative payment mod-
18 els (as defined in section 1833(z)(3)(D))
19 and, to the extent feasible, the names of
20 such eligible alternative payment models
21 and performance of such models.

22 “(B) DISCLOSURE.—The information
23 made available under this paragraph shall indi-
24 cate, where appropriate, that publicized infor-
25 mation may not be representative of the eligible

1 professional's entire patient population, the va-
2 riety of services furnished by the eligible profes-
3 sional, or the health conditions of individuals
4 treated.

5 “(C) OPPORTUNITY TO REVIEW AND SUB-
6 MIT CORRECTIONS.—The Secretary shall pro-
7 vide for an opportunity for a professional de-
8 scribed in subparagraph (A) to review, and sub-
9 mit corrections for, the information to be made
10 public with respect to the professional under
11 such subparagraph prior to such information
12 being made public.

13 “(D) AGGREGATE INFORMATION.—The
14 Secretary shall periodically post on the Physi-
15 cian Compare Internet website aggregate infor-
16 mation on the VBP program, including the
17 range of composite scores for all VBP eligible
18 professionals and the range of the performance
19 of all VBP eligible professionals with respect to
20 each performance category.

21 “(11) CONSULTATION.—The Secretary shall
22 consult with stakeholders in carrying out the VBP
23 program, including for the identification of measures
24 and activities under paragraph (2)(B) and the meth-
25 odologies developed under paragraphs (5)(A) and

1 (7). Such consultation shall include the use of a re-
2 quest for information or other mechanisms deter-
3 mined appropriate.

4 “(12) TECHNICAL ASSISTANCE TO SMALL PRAC-
5 TICES AND PRACTICES IN HEALTH PROFESSIONAL
6 SHORTAGE AREAS.—

7 “(A) IN GENERAL.—The Secretary shall
8 enter into contracts or agreements with appro-
9 priate entities (such as quality improvement or-
10 ganizations, regional extension centers (as de-
11 scribed in section 3012(c) of the Public Health
12 Service Act), or regional health collaboratives)
13 to offer guidance and assistance to VBP eligible
14 professionals in practices of fewer than 20 pro-
15 fessionals (with priority given to such practices
16 located in rural areas, health professional short-
17 age areas (as designated under in section
18 332(a)(1)(A) of the Public Health Service Act),
19 or practices with low composite scores) with re-
20 spect to—

21 “(i) the performance categories de-
22 scribed in clauses (i) through (iv) of para-
23 graph (2)(A); or

24 “(ii) how to transition to the imple-
25 mentation of and participation in an alter-

1 native payment model as described in sec-
2 tion 1833(z)(3)(C).

3 “(B) FUNDING FOR IMPLEMENTATION.—

4 For purposes of implementing subparagraph
5 (A), the Secretary shall provide for the transfer
6 from the Federal Supplementary Medical Insur-
7 ance Trust Fund established under section
8 1841 to the Centers for Medicare & Medicaid
9 Services Program Management Account of
10 \$50,000,000 for each of fiscal years 2014
11 through 2018. Amounts transferred under this
12 subparagraph for a fiscal year shall be available
13 until expended.

14 “(13) FEEDBACK AND INFORMATION TO IM-
15 PROVE PERFORMANCE.—

16 “(A) PERFORMANCE FEEDBACK.—

17 “(i) IN GENERAL.—Beginning July 1,
18 2015, the Secretary—

19 “(I) shall make available timely
20 (such as quarterly) confidential feed-
21 back to each VBP eligible professional
22 on the performance of such profes-
23 sional with respect to the performance
24 categories under clauses (i) and (ii) of
25 paragraph (2)(A); and

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

7 “(ii) MECHANISMS.—The Secretary
8 may use one or more mechanisms to make
9 feedback available under clause (i), which
10 may include use of a web-based portal or
11 other mechanisms determined appropriate
12 by the Secretary. The Secretary shall en-
13 courage provision of feedback through
14 qualified clinical data registries as de-
15 scribed in subsection (m)(3)(E)).

16 “(iii) USE OF DATA.—For purposes of
17 clause (i), the Secretary may use data,
18 with respect to a VBP eligible professional,
19 from periods prior to the current perform-
20 ance period and may use rolling periods in
21 order to make illustrative calculations
22 about the performance of such profes-
23 sional.

24 “(iv) DISCLOSURE EXEMPTION.—
25 Feedback made available under this sub-

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

4 “(v) RECEIPT OF INFORMATION.—
5 The Secretary may use the mechanisms es-
6 tablished under clause (ii) to receive infor-
7 mation from professionals, such as infor-
8 mation with respect to this subsection.

9 “(B) ADDITIONAL INFORMATION.—

10 “(i) IN GENERAL.—Beginning July 1,
11 2016, the Secretary shall make available to
12 each VBP eligible professional information,
13 with respect to individuals who are pa-
14 tients of such VBP eligible professional,
15 about items and services for which pay-
16 ment is made under this title that are fur-
17 nished to such individuals by other sup-
18 pliers and providers of services, which may
19 include information described in clause (ii).
20 Such information shall be made available
21 under the previous sentence to such VBP
22 eligible professionals by mechanisms deter-
23 mined appropriate by the Secretary, which
24 may include use of a web-based portal.
25 Such information shall be made available

1 in accordance with the same or similar
2 terms as data are made available to ac-
3 countable care organizations under section
4 1899, including a beneficiary opt-out.

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

8 “(I) With respect to selected
9 items and services (as determined ap-
10 propriate by the Secretary) for which
11 payment is made under this title and
12 that are furnished to individuals, who
13 are patients of a VBP eligible profes-
14 sional, by another supplier or provider
15 of services during the most recent pe-
16 riod for which data are available (such
17 as the most recent three-month pe-
18 riod), the name of such providers fur-
19 nishing such items and services to
20 such patients during such period, the
21 types of such items and services so
22 furnished, and the dates such items
23 and services were so furnished.

24 “(II) Historical averages (and
25 other measures of the distribution if

1 appropriate) of the total, and compo-
2 nents of, allowed charges (and other
3 figures as determined appropriate by
4 the Secretary) for care episodes for
5 such period.

6 “(14) REVIEW.—

7 “(A) TARGETED REVIEW.—The Secretary
8 shall establish a process under which a VBP eli-
9 gible professional may seek an informal review
10 of the calculation of the VBP program incentive
11 payment adjustment factor applicable to such
12 eligible professional under this subsection for a
13 year. The results of a review conducted pursu-
14 ant to the previous sentence shall not be taken
15 into account for purposes of paragraph (7) with
16 respect to a year (other than with respect to the
17 calculation of such eligible professional’s VBP
18 program incentive payment adjustment factor
19 for such year) after the factors determined in
20 subparagraph (A) of such paragraph have been
21 determined for such year.

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

1 “(i) The methodology used to deter-
2 mine the amount of the VBP program in-
3 centive payment adjustment factor under
4 paragraph (7) and the determination of
5 such amount.

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

11 “(iii) The establishment of the per-
12 formance standards under paragraph (3)
13 and the performance period under para-
14 graph (4).

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

21 “(v) The methodology developed under
22 paragraph (5) that is used to calculate per-
23 formance scores and the calculation of
24 such scores, including the weighting of

1 measures and activities under such meth-
2 odology.”.

3 (2) GAO REPORTS.—

4 (A) EVALUATION OF ELIGIBLE PROFES-
5 SIONAL VBP PROGRAM.—Not later than October
6 1, 2018, and October 1, 2021, the Comptroller
7 General of the United States shall submit to
8 Congress a report evaluating the eligible profes-
9 sional value-based performance incentive pro-
10 gram under subsection (q) of section 1848 of
11 the Social Security Act (42 U.S.C. 1395w–4),
12 as added by paragraph (1). Such report shall—

13 (i) examine the distribution of the
14 performance and incentive payments for
15 VBP eligible professionals (as defined in
16 subsection (q)(1)(C) of such section) under
17 such program, and patterns relating to
18 such performance and incentive payments,
19 including based on type of provider, prac-
20 tice size, geographic location, and patient
21 mix; and

22 (ii) provide recommendations for im-
23 proving such program.

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

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

5 (i) compares the similarities and dif-
6 ferences in the use of quality measures
7 under the original medicare fee-for-service
8 program under parts A and B of title
9 XVIII of the Social Security Act, the Medi-
10 care Advantage program under part C of
11 such title, and private payer arrangements;
12 and

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

16 (3) FUNDING FOR IMPLEMENTATION.—For
17 purposes of implementing the provisions of and the
18 amendments made by this section, the Secretary of
19 Health and Human Services shall provide for the
20 transfer of \$50,000,000 from the Supplementary
21 Medical Insurance Trust Fund established under
22 section 1841 of the Social Security Act (42 U.S.C.
23 1395t) to the Centers for Medicare & Medicaid Pro-
24 gram Management Account for each of the fiscal
25 years 2014 through 2017. Amounts transferred

1 under this paragraph shall be available until ex-
2 pended.

3 (d) IMPROVING QUALITY REPORTING FOR COM-
4 POSITE SCORES.—

5 (1) CHANGES FOR GROUP REPORTING OP-
6 TION.—

7 (A) IN GENERAL.—Section
8 1848(m)(3)(C)(ii) of the Social Security Act
9 (42 U.S.C. 1395w-4(m)(3)(C)(ii)) is amended
10 by inserting “and, for 2014 and subsequent
11 years, may provide” after “shall provide”.

12 (B) CLARIFICATION OF QUALIFIED CLIN-
13 ICAL DATA REGISTRY REPORTING TO GROUP
14 PRACTICES.—Section 1848(m)(3)(D) of the So-
15 cial Security Act (42 U.S.C. 1395w-
16 4(m)(3)(D)) is amended by inserting “and, for
17 2015 and subsequent years, subparagraph (A)
18 or (C)” after “subparagraph (A)”.

19 (2) CHANGES FOR MULTIPLE REPORTING PERI-
20 ODS AND ALTERNATIVE CRITERIA FOR SATISFAC-
21 TORY REPORTING.—Section 1848(m)(5)(F)) of the
22 Social Security Act (42 U.S.C. 1395w-4(m)(5)(F))
23 is amended—

1 (A) by striking “and subsequent years”
2 and inserting “through reporting periods occur-
3 ring in 2013”; and

4 (B) by inserting “and, for reporting peri-
5 ods occurring in 2014 and subsequent years,
6 the Secretary may establish” following “shall
7 establish”.

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

13 “(11) REPORTS ENDING WITH 2016.—Reports
14 under the Program shall not be provided after De-
15 cember 31, 2016. See subsection (q)(13) for reports
16 beginning with 2017.”.

17 (4) COORDINATION WITH SATISFYING MEANING-
18 FUL EHR USE CLINICAL QUALITY MEASURE REPORT-
19 ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of
20 the Social Security Act (42 U.S.C. 1395w-
21 4(o)(2)(A)(iii)) is amended by inserting “and sub-
22 section (q)(5)(C)(ii)(II)” after “Subject to subpara-
23 graph (B)(ii)”.

24 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

1 (1) INCENTIVE PAYMENTS FOR PARTICIPATION
2 IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—
3 Section 1833 of the Social Security Act (42 U.S.C.
4 1395l) is amended by adding at the end the fol-
5 lowing new subsection:

6 “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN
7 ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

8 “(1) PAYMENT INCENTIVE.—

9 “(A) IN GENERAL.—In the case of covered
10 professional services furnished by an eligible
11 professional during a year that is in the period
12 beginning with 2017 and ending with 2022 and
13 for which the professional is a qualifying APM
14 participant, in addition to the amount of pay-
15 ment that would otherwise be made for such
16 covered professional services under this part for
17 such year, there also shall be paid to such pro-
18 fessional an amount equal to 5 percent of the
19 payment amount for the covered professional
20 services under this part for the preceding year.
21 For purposes of the previous sentence, the pay-
22 ment amount for the preceding year may be an
23 estimation for the full preceding year based on
24 a period of such preceding year that is less than
25 the full year. The Secretary shall establish poli-

1 cies to implement this subparagraph in cases
2 where payment for covered professional services
3 furnished by a qualifying APM participant in
4 an alternative payment model is made to an en-
5 tity participating in the alternative payment
6 model rather than directly to the qualifying
7 APM participant.

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

11 “(C) TREATMENT OF PAYMENT INCEN-
12 TIVE.—Payments under this subsection shall
13 not be taken into account for purposes of deter-
14 mining actual expenditures under an alternative
15 payment model and for purposes of determining
16 or rebasing any benchmarks used under the al-
17 ternative payment model.

18 “(D) COORDINATION.—The amount of the
19 additional payment for an item or service under
20 this subsection or subsection (m) shall be deter-
21 mined without regard to any additional pay-
22 ment for the item or service under subsection
23 (m) and this subsection, respectively. The
24 amount of the additional payment for an item
25 or service under this subsection or subsection

1 (x) shall be determined without regard to any
2 additional payment for the item or service
3 under subsection (x) and this subsection, re-
4 spectively. The amount of the additional pay-
5 ment for an item or service under this sub-
6 section or subsection (y) shall be determined
7 without regard to any additional payment for
8 the item or service under subsection (y) and
9 this subsection, respectively.

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

13 “(A) 2017 AND 2018.—With respect to
14 2017 and 2018, an eligible professional for
15 whom the Secretary determines that at least 25
16 percent of payments under this part for covered
17 professional services furnished by such profes-
18 sional during the most recent period for which
19 data are available (which may be less than a
20 year) were attributable to such services fur-
21 nished under this part through an entity that
22 participates in an eligible alternative payment
23 model with respect to such services.

1 “(B) 2019 AND 2020.—With respect to
2 2019 and 2020, an eligible professional de-
3 scribed in either of the following clauses:

4 “(i) MEDICARE REVENUE THRESHOLD
5 OPTION.—An eligible professional for
6 whom the Secretary determines that at
7 least 50 percent of payments under this
8 part for covered professional services fur-
9 nished by such professional during the
10 most recent period for which data are
11 available (which may be less than a year)
12 were attributable to such services furnished
13 under this part through an entity that par-
14 ticipates in an eligible alternative payment
15 model with respect to such services.

16 “(ii) COMBINATION ALL-PAYER AND
17 MEDICARE REVENUE THRESHOLD OP-
18 TION.—An eligible professional—

19 “(I) for whom the Secretary de-
20 termines, with respect to items and
21 services furnished by such professional
22 during the most recent period for
23 which data are available (which may
24 be less than a year), that at least 50
25 percent of the sum of—

1 “(aa) payments described in
2 clause (i); and

3 “(bb) all other payments, re-
4 gardless of payer (other than
5 payments made by the Secretary
6 of Defense or the Secretary of
7 Veterans Affairs under chapter
8 55 of title 10, United States
9 Code, or title 38, United States
10 Code, or any other provision of
11 law),

12 meet the requirement described in
13 clause (iii)(I) with respect to pay-
14 ments described in item (aa) and meet
15 the requirement described in clause
16 (iii)(II) with respect to payments de-
17 scribed in item (bb);

18 “(II) for whom the Secretary de-
19 termines at least 25 percent of pay-
20 ments under this part for covered pro-
21 fessional services furnished by such
22 professional during the preceding year
23 were attributable to such services fur-
24 nished under this part through an en-
25 tity that participates in an eligible al-

1 ternative payment model with respect
2 to such services; and

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

8 “(iii) REQUIREMENT.—For purposes
9 of clause (ii)(I)—

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

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

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

1 “(bb) certified EHR tech-
2 nology is used; and

3 “(cc) the eligible profes-
4 sional bears more than nominal
5 financial risk if actual aggregate
6 expenditures exceeds expected ag-
7 gregate expenditures.

8 “(C) BEGINNING IN 2021.—With respect to
9 2021 and each subsequent year, an eligible pro-
10 fessional described in either of the following
11 clauses:

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

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

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

11 “(aa) payments described in
12 clause (i); and

13 “(bb) all other payments, re-
14 gardless of payer (other than
15 payments made by the Secretary
16 of Defense or the Secretary of
17 Veterans Affairs under chapter
18 55 of title 10, United States
19 Code, or title 38, United States
20 Code, or any other provision of
21 law),

22 meet the requirement described in
23 clause (iii)(I) with respect to pay-
24 ments described in item (aa) and meet
25 the requirement described in clause

1 (iii)(II) with respect to payments de-
2 scribed in item (bb);

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

15 “(III) who provides to the Sec-
16 retary such information as is nec-
17 essary for the Secretary to make a de-
18 termination under subclause (I), with
19 respect to such professional.

20 “(iii) REQUIREMENT.—For purposes
21 of clause (ii)(I)—

22 “(I) the requirement described in
23 this subclause, with respect to pay-
24 ments described in item (aa) of such
25 clause, is that such payments are

1 made under an eligible alternative
2 payment model; and

3 “(II) the requirement described
4 in this subclause, with respect to pay-
5 ments described in item (bb) of such
6 clause, is that such payments are
7 made under an arrangement in
8 which—

9 “(aa) quality measures com-
10 parable to measures under the
11 performance category described
12 in section 1848(q)(2)(B)(i) apply;

13 “(bb) certified EHR tech-
14 nology is used; and

15 “(cc) the eligible profes-
16 sional bears more than nominal
17 financial risk if actual aggregate
18 expenditures exceeds expected ag-
19 gregate expenditures.

20 “(2) ADDITIONAL DEFINITIONS.—In this sub-
21 section:

22 “(A) COVERED PROFESSIONAL SERV-
23 ICES.—The term ‘covered professional services’
24 has the meaning given that term in section
25 1848(k)(3)(A).

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

4 “(C) ALTERNATIVE PAYMENT MODEL
5 (APM).—The term ‘alternative payment model’
6 means any of the following:

7 “(i) A model under section 1115A
8 (other than a health care innovation
9 award).

10 “(ii) An accountable care organization
11 under section 1899.

12 “(iii) A demonstration under section
13 1866C.

14 “(iv) A demonstration required by
15 Federal law.

16 “(D) ELIGIBLE ALTERNATIVE PAYMENT
17 MODEL (APM).—

18 “(i) IN GENERAL.—The term ‘eligible
19 alternative payment model’ means, with re-
20 spect to a year, an alternative payment
21 model—

22 “(I) that requires use of certified
23 EHR technology (as defined in sub-
24 section (o)(4));

1 “(II) that provides for payment
2 for covered professional services based
3 on quality measures comparable to
4 measures under the performance cat-
5 egory described in section
6 1848(q)(2)(B)(i); and

7 “(III) that satisfies the require-
8 ment described in clause (ii).

9 “(ii) ADDITIONAL REQUIREMENT.—
10 For purposes of clause (i)(III), the require-
11 ment described in this clause, with respect
12 to a year and an alternative payment
13 model, is that the alternative payment
14 model—

15 “(I) is one in which one or more
16 entities bear financial risk for mone-
17 tary losses under such model that are
18 in excess of a nominal amount; or

19 “(II) is a medical home expanded
20 under section 1115A(e).

21 “(3) LIMITATION.—There shall be no adminis-
22 trative or judicial review under section 1869, 1878,
23 or otherwise, of the following:

24 “(A) The determination that an eligible
25 professional is a qualifying APM participant

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

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

9 (2) COORDINATION CONFORMING AMEND-
10 MENTS.—Section 1833 of the Social Security Act
11 (42 U.S.C. 1395l) is further amended—

12 (A) in subsection (x)(3), by adding at the
13 end the following new sentence: “The amount
14 of the additional payment for a service under
15 this subsection and subsection (z) shall be de-
16 termined without regard to any additional pay-
17 ment for the service under subsection (z) and
18 this subsection, respectively.”; and

19 (B) in subsection (y)(3), by adding at the
20 end the following new sentence: “The amount
21 of the additional payment for a service under
22 this subsection and subsection (z) shall be de-
23 termined without regard to any additional pay-
24 ment for the service under subsection (z) and
25 this subsection, respectively.”.

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

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

7 “(xxi) Focusing primarily on physi-
8 cians’ services (as defined in section
9 1848(j)(3)) furnished by physicians who
10 are not primary care practitioners.

11 “(xxii) Focusing on practices of fewer
12 than 20 professionals.”; and

13 (B) in subparagraph (C)(viii), by striking
14 “other public sector or private sector payers”
15 and inserting “other public sector payers, pri-
16 vate sector payers, or Statewide payment mod-
17 els”.

18 (f) STUDY AND REPORT ON FRAUD RELATED TO AL-
19 TERNATIVE PAYMENT MODELS UNDER THE MEDICARE
20 PROGRAM.—

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

1 (A) examines the applicability of the Fed-
2 eral fraud prevention laws to items and services
3 furnished under title XVIII of the Social Secu-
4 rity Act for which payment is made under an
5 alternative payment model (as defined in sec-
6 tion 1833(z)(3)(C) of such Act (42 U.S.C.
7 1395l(z)(3)(C)));

8 (B) identifies aspects of such alternative
9 payment models that are vulnerable to fraudu-
10 lent activity; and

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

15 (2) REPORT.—Not later than 2 years after the
16 date of the enactment of this Act, the Secretary
17 shall submit to Congress a report containing the re-
18 sults of the study conducted under paragraph (1).
19 Such report shall include recommendations for ac-
20 tions to be taken to reduce the vulnerability of such
21 alternative payment models to fraudulent activity.
22 Such report also shall include, as appropriate, rec-
23 ommendations of the Inspector General for changes
24 in Federal fraud prevention laws to reduce such vul-
25 nerability.

1 (g) IMPROVING PAYMENT ACCURACY.—

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

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

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

1 sistant Secretary for Planning and Evalua-
2 tion.

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

8 (B) STUDY USING OTHER DATA.—

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

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

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

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

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

1 (i) obtain access to the necessary data
2 (if such data is not already being collected)
3 on such factors, including recommenda-
4 tions on how to address barriers to the
5 Centers in accessing such data; and

6 (ii) account for such factors in deter-
7 mining payment adjustments based on
8 quality and resource use outcome measures
9 under the eligible professional value-based
10 performance incentive program under sec-
11 tion 1848(q) of the Social Security Act (42
12 U.S.C. 1395w-4(q)) and, as the Secretary
13 determines appropriate, other similar pro-
14 visions of title XVIII of such Act.

15 (E) FUNDING.—There are hereby appro-
16 priated from the Federal Supplemental Medical
17 Insurance Trust Fund to the Secretary to carry
18 out this paragraph \$6,000,000, to remain avail-
19 able until expended.

20 (2) CMS ACTIVITIES.—

21 (A) HIERARCHICAL CONDITION CATEGORY
22 (HCC) IMPROVEMENT.—Taking into account the
23 relevant studies conducted and recommenda-
24 tions made in reports under paragraph (1), the
25 Secretary, on an ongoing basis, shall estimate

1 how an individual's health status and other risk
2 factors affect quality and resource use outcome
3 measures and, as feasible, shall incorporate in-
4 formation from quality and resource use out-
5 come measurement (including care episode and
6 patient condition groups) into the eligible pro-
7 fessional value-based performance incentive pro-
8 gram under section 1848(q) of the Social Secu-
9 rity Act and, as the Secretary determines ap-
10 propriate, other similar provisions of title XVIII
11 of such Act.

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

14 (i) IN GENERAL.—Taking into ac-
15 count the studies conducted and rec-
16 ommendations made in reports under para-
17 graph (1), the Secretary shall account for
18 identified factors (other than those applied
19 under subparagraph (A)) with an effect on
20 quality and resource use outcome measures
21 when determining payment adjustments
22 under the eligible professional value-based
23 performance incentive program under sec-
24 tion 1848(q) of the Social Security Act
25 and, as the Secretary determines appro-

1 appropriate, other similar provisions of title
2 XVIII of such Act.

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

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

13 (C) FUNDING.—There are hereby appro-
14 priated from the Federal Supplemental Medical
15 Insurance Trust Fund to the Secretary to carry
16 out this paragraph \$10,000,000, to remain
17 available until expended.

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

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

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

10 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-
11 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
12 IMPROVE RESOURCE USE MEASUREMENT.—

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

22 “(2) DEVELOPMENT OF CARE EPISODE AND PA-
23 TIENT CONDITION GROUPS AND CLASSIFICATION
24 CODES.—

1 “(A) IN GENERAL.—In order to classify
2 similar patients into distinct care episode
3 groups and distinct patient condition groups,
4 the Secretary shall undertake the steps de-
5 scribed in the succeeding provisions of this
6 paragraph.

7 “(B) PUBLIC AVAILABILITY OF EXISTING
8 EFFORTS TO DESIGN AN EPISODE GROUPEE.—
9 Not later than 60 days after the date of the en-
10 actment of this subsection, the Secretary shall
11 post on the Internet website of the Centers for
12 Medicare & Medicaid Services a list of the epi-
13 sode groups developed pursuant to subsection
14 (n)(9)(A) and related descriptive information.

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

25 “(i) distinct care episode groups; and

1 “(ii) distinct patient condition groups.

2 “(D) DEVELOPMENT OF PROPOSED CLAS-
3 SIFICATION CODES.—

4 “(i) IN GENERAL.—Taking into ac-
5 count the information described in sub-
6 paragraph (B) and the information re-
7 ceived under subparagraph (C), the Sec-
8 retary shall—

9 “(I) establish distinct care epi-
10 sode groups and distinct patient con-
11 dition groups, which account for at
12 least an estimated two-thirds of ex-
13 penditures under parts A and B; and

14 “(II) assign codes to such
15 groups.

16 “(ii) CARE EPISODE GROUPS.—In es-
17 tablishing the care episode groups under
18 clause (i), the Secretary shall take into ac-
19 count—

20 “(I) the patient’s clinical prob-
21 lems at the time items and services
22 are furnished during an episode of
23 care, such as the clinical conditions or
24 diagnoses, whether or not inpatient
25 hospitalization is anticipated or oc-

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

3 “(II) other factors determined
4 appropriate by the Secretary.

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

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

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

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

1 of the comment period described in subpara-
2 graph (C), the Secretary shall post on the
3 Internet website of the Centers for Medicare &
4 Medicaid Services a draft list of the care epi-
5 sode and patient condition codes established
6 under subparagraph (D) (and the criteria and
7 characteristics assigned to such code).

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

23 “(G) OPERATIONAL LIST OF CARE EPI-
24 SODE AND PATIENT CONDITION GROUPS AND
25 CODES.—Not later than 120 days after the end

1 of the comment period described in subpara-
2 graph (F), taking into account the comments
3 received under such subparagraph, the Sec-
4 retary shall post on the Internet website of the
5 Centers for Medicare & Medicaid Services an
6 operational list of care episode and patient con-
7 dition codes (and the criteria and characteris-
8 tics assigned to such code).

9 “(H) SUBSEQUENT REVISIONS.—Not later
10 than November 1 of each year (beginning with
11 2016), the Secretary shall, through rulemaking,
12 make revisions to the operational lists of care
13 episode and patient condition codes as the Sec-
14 retary determines may be appropriate. Such re-
15 visions may be based on experience, new infor-
16 mation developed pursuant to subsection
17 (n)(9)(A), and input from the physician spe-
18 cialty societies, applicable practitioner organiza-
19 tions, and other stakeholders, including rep-
20 resentatives of individuals entitled to benefits
21 under part A or enrolled under this part.

22 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-
23 CIANS OR PRACTITIONERS.—

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

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

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

19 “(i) considers themselves to have the
20 primary responsibility for the general and
21 ongoing care for the patient over extended
22 periods of time;

23 “(ii) considers themselves to be the lead
24 physician or practitioner and who furnishes
25 items and services and coordinates care

1 furnished by other physicians or practi-
2 tioners for the patient during an acute epi-
3 sode;

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

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

12 “(v) furnishes items and services only
13 as ordered by another physician or practi-
14 tioner.

15 “(C) DRAFT LIST OF PATIENT RELATION-
16 SHIP CATEGORIES AND CODES.—Not later than
17 180 days after the date of the enactment of this
18 subsection, the Secretary shall post on the
19 Internet website of the Centers for Medicare &
20 Medicaid Services a draft list of the patient re-
21 lationship categories and codes developed under
22 subparagraph (B).

23 “(D) STAKEHOLDER INPUT.—The Sec-
24 retary shall seek, through the date that is 60
25 days after the Secretary posts the list pursuant

1 to subparagraph (C), comments from physician
2 specialty societies, applicable practitioner orga-
3 nizations, and other stakeholders, including rep-
4 resentatives of individuals entitled to benefits
5 under part A or enrolled under this part, re-
6 garding the patient relationship categories and
7 codes posted under subparagraph (C). In seek-
8 ing such comments, the Secretary shall use one
9 or more mechanisms (other than notice and
10 comment rulemaking) that may include open
11 door forums, town hall meetings, or other ap-
12 propriate mechanisms.

13 “(E) OPERATIONAL LIST OF PATIENT RE-
14 LATIONSHIP CATEGORIES AND CODES.—Not
15 later than 120 days after the end of the com-
16 ment period described in subparagraph (D),
17 taking into account the comments received
18 under such subparagraph, the Secretary shall
19 post on the Internet website of the Centers for
20 Medicare & Medicaid Services an operational
21 list of patient relationship categories and codes.

22 “(F) SUBSEQUENT REVISIONS.—Not later
23 than November 1 of each year (beginning with
24 2016), the Secretary shall, through rulemaking,
25 make revisions to the operational list of patient

1 relationship categories and codes as the Sec-
2 retary determines appropriate. Such revisions
3 may be based on experience, new information
4 developed pursuant to subsection (n)(9)(A), and
5 input from the physician specialty societies, ap-
6 plicable practitioner organizations, and other
7 stakeholders, including representatives of indi-
8 viduals entitled to benefits under part A or en-
9 rolled under this part.

10 “(4) REPORTING OF INFORMATION FOR RE-
11 SOURCE USE MEASUREMENT.—Claims submitted for
12 items and services furnished by a physician or appli-
13 cable practitioner on or after January 1, 2016, shall,
14 as determined appropriate by the Secretary, in-
15 clude—

16 “(A) applicable codes established under
17 paragraphs (2) and (3); and

18 “(B) the national provider identifier of the
19 ordering physician or applicable practitioner (if
20 different from the billing physician or applicable
21 practitioner).

22 “(5) METHODOLOGY FOR RESOURCE USE ANAL-
23 YSIS.—

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

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

3 “(i) use the patient relationship codes
4 reported on claims pursuant to paragraph
5 (4) to attribute patients (in whole or in
6 part) to one or more physicians and appli-
7 cable practitioners;

8 “(ii) use the care episode and patient
9 condition codes reported on claims pursu-
10 ant to paragraph (4) as a basis to compare
11 similar patients and care episodes and pa-
12 tient condition groups; and

13 “(iii) conduct an analysis of resource
14 use (with respect to care episodes and pa-
15 tient condition groups of such patients), as
16 the Secretary determines appropriate.

17 “(B) ANALYSIS OF PATIENTS OF PHYSI-
18 CIANS AND PRACTITIONERS.—In conducting the
19 analysis described in subparagraph (A)(iii) with
20 respect to patients attributed to physicians and
21 applicable practitioners, the Secretary shall, as
22 feasible—

23 “(i) use the claims data experience of
24 such patients by patient condition codes

1 during a common period, such as 12
2 months; and

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

5 “(I) in the case of episodes with-
6 out a hospitalization, during periods
7 of time (such as the number of days)
8 determined appropriate by the Sec-
9 retary; and

10 “(II) in the case of episodes with
11 a hospitalization, during periods of
12 time (such as the number of days) be-
13 fore, during, and after the hospitaliza-
14 tion.

15 “(C) MEASUREMENT OF RESOURCE USE.—
16 In measuring such resource use, the Sec-
17 retary—

18 “(i) shall use per patient total allowed
19 amounts for all services under part A and
20 this part (and, if the Secretary determines
21 appropriate, part D) for the analysis of pa-
22 tient resource use, by care episode codes
23 and by patient condition codes; and

24 “(ii) may, as determined appropriate,
25 use other measures of allowed amounts

1 (such as subtotals for categories of items
2 and services) and measures of utilization of
3 items and services (such as frequency of
4 specific items and services and the ratio of
5 specific items and services among attrib-
6 uted patients or episodes).

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

20 “(6) LIMITATION.—There shall be no adminis-
21 trative or judicial review under section 1869, section
22 1878, or otherwise of—

23 “(A) care episode and patient condition
24 groups and codes established under paragraph
25 (2);

1 “(B) patient relationship categories and
2 codes established under paragraph (3); and

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

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

9 “(8) DEFINITIONS.—In this section:

10 “(A) PHYSICIAN.—The term ‘physician’
11 has the meaning given such term in section
12 1861(r)(1).

13 “(B) APPLICABLE PRACTITIONER.—The
14 term ‘applicable practitioner’ means—

15 “(i) a physician assistant, nurse prac-
16 titioner, and clinical nurse specialist (as
17 such terms are defined in section
18 1861(aa)(5)); and

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

23 “(9) CLARIFICATION.—The provisions of sec-
24 tions 1890(b)(7) and 1890A shall not apply to this
25 subsection.”.

1 **SEC. 3. PRIORITIES AND FUNDING FOR QUALITY MEASURE**
2 **DEVELOPMENT.**

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

7 “(s) **PRIORITIES AND FUNDING FOR QUALITY MEAS-**
8 **URE DEVELOPMENT.**—

9 “(1) **PLAN IDENTIFYING MEASURE DEVELOP-**
10 **MENT PRIORITIES AND TIMELINES.**—

11 “(A) **DRAFT MEASURE DEVELOPMENT**
12 **PLAN.**—

13 “(i) **DRAFT PLAN.**—

14 “(I) **IN GENERAL.**—Not later
15 than October 1, 2014, the Secretary
16 shall develop, and post on the Internet
17 website of the Centers for Medicare &
18 Medicaid Services, a draft plan for the
19 development of quality measures for
20 application under the applicable provi-
21 sions.

22 “(II) **REQUIREMENT.**—Such plan
23 shall address how measures used by
24 private payers and integrated delivery
25 systems could be incorporated under
26 such subsection.

1 “(ii) CONSIDERATION.—In developing
2 the draft plan under subparagraph (A), the
3 Secretary shall consider—

4 “(I) gap analyses conducted by
5 the entity with a contract under sec-
6 tion 1890(a) or other contractors or
7 entities; and

8 “(II) whether measures are appli-
9 cable across health care settings.

10 “(iii) PRIORITIES.—In developing the
11 draft plan under subparagraph (A), the
12 Secretary shall give priority to the fol-
13 lowing types of measures:

14 “(I) Outcome measures including
15 patient reported outcome and func-
16 tional status measures.

17 “(II) Patient experience meas-
18 ures.

19 “(III) Care coordination meas-
20 ures.

21 “(IV) Measures of appropriate
22 use of services, including measures of
23 over use.

24 “(iv) DEFINITION OF APPLICABLE
25 PROVISIONS.—In this subsection, the term

1 ‘applicable provisions’ means the following
2 provisions:

3 “(I) Subsection (q)(2)(B)(i).

4 “(II) Section 1833(z)(2)(C).

5 “(B) STAKEHOLDER INPUT.—The Sec-
6 retary shall accept through December 1, 2014,
7 comments on the draft plan posted under para-
8 graph (1)(A) from the public, including health
9 care providers, payers, consumers, and other
10 stakeholders.

11 “(C) OPERATIONAL MEASURE DEVELOP-
12 MENT PLAN.—Not later than February 1, 2015,
13 taking into account the comments received
14 under subparagraph (B), the Secretary shall
15 post on the Internet website of the Centers for
16 Medicare & Medicaid Services an operational
17 plan for the development of quality measures
18 for use under subsection (q)(2)(A)(i).

19 “(2) CONTRACTS AND OTHER ARRANGEMENTS
20 FOR QUALITY MEASURE DEVELOPMENT.—

21 “(A) IN GENERAL.—The Secretary shall
22 enter into contracts or other arrangements with
23 entities for the purpose of developing, improv-
24 ing, updating, or expanding quality measures
25 for application under the applicable provisions.

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

3 “(B) PRIORITIZATION.—

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

10 “(ii) CONSIDERATION.—In selecting
11 measures for development under this sub-
12 section, the Secretary shall consider wheth-
13 er such measures would be electronically
14 specified.

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

16 “(A) IN GENERAL.—Not later than Feb-
17 ruary 1, 2016, and annually thereafter, the Sec-
18 retary shall post on the Internet website of the
19 Centers for Medicare & Medicaid Services a re-
20 port on the progress made in developing quality
21 measures for application under the applicable
22 provisions.

23 “(B) REQUIREMENTS.—Each report sub-
24 mitted pursuant to paragraph (1) shall include
25 the following:

1 “(i) A description of the Secretary’s
2 efforts to implement this subsection.

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

5 “(I) a description of the total
6 number of quality measures developed
7 and the types of such measures, such
8 as an outcome or patient experience
9 measure;

10 “(II) the name of each measure
11 developed;

12 “(III) the name of the developer
13 and steward of each measure;

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

18 “(V) whether the measure would
19 be electronically specified.

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

22 “(I) the information described in
23 clause (ii), if available; and

24 “(II) a timeline for completion of
25 the development of such measures.

1 “(iv) An update on the progress in de-
2 veloping the types of measures described in
3 paragraph (1)(A)(iii), including a descrip-
4 tion of issues affecting such progress.

5 “(v) A list of quality topics and con-
6 cepts that are being considered for develop-
7 ment of measures and the rationale for the
8 selection of topics and concepts including
9 their relationship to gap analyses.

10 “(vi) A description of any updates to
11 the plan under paragraph (1) (including
12 newly identified gaps and the status of pre-
13 viously identified gaps) and the inventory
14 of measures applicable under the applicable
15 provisions.

16 “(vii) Other information the Secretary
17 determines to be appropriate.

18 “(4) STAKEHOLDER INPUT.—With respect to
19 measures applicable under the applicable provisions,
20 the Secretary shall seek stakeholder input with re-
21 spect to—

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

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

3 “(C) other areas related to quality measure
4 development determined appropriate by the Sec-
5 retary.

6 “(5) FUNDING.—For purposes of carrying out
7 this subsection, the Secretary shall provide for the
8 transfer, from the Federal Supplementary Medical
9 Insurance Trust Fund under section 1841, of
10 \$15,000,000 to the Centers for Medicare & Medicaid
11 Services Program Management Account for each of
12 fiscal years 2014 through 2018. Amounts trans-
13 ferred under this paragraph shall remain available
14 through the end of fiscal year 2021.”.

15 **SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVID-**
16 **UALS WITH CHRONIC CARE NEEDS.**

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

20 “(8) ENCOURAGING CARE MANAGEMENT FOR
21 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

22 “(A) IN GENERAL.—In order to encourage
23 the management of care by an applicable pro-
24 vider (as defined in subparagraph (B)) for indi-

1 viduals with chronic care needs the Secretary
2 shall—

3 “(i) establish one or more HCPCS
4 codes for chronic care management serv-
5 ices for such individuals; and

6 “(ii) subject to subparagraph (D),
7 make payment (as the Secretary deter-
8 mines to be appropriate) under this section
9 for such management services furnished on
10 or after January 1, 2015, by an applicable
11 provider.

12 “(B) APPLICABLE PROVIDER DEFINED.—
13 For purposes of this paragraph, the term ‘ap-
14 plicable provider’ means a physician (as defined
15 in section 1861(r)(1)), physician assistant or
16 nurse practitioner (as defined in section
17 1861(aa)(5)(A)), or clinical nurse specialist (as
18 defined in section 1861(aa)(5)(B)) who fur-
19 nishes services as part of a patient-centered
20 medical home or a comparable specialty practice
21 that—

22 “(i) is recognized as such a medical
23 home or comparable specialty practice by
24 an organization that is recognized by the

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

3 “(ii) 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) POLICIES RELATING TO PAYMENT.—
11 In carrying out this paragraph, with respect to
12 chronic care management services, the Sec-
13 retary shall—

14 “(i) make payment to only one appli-
15 cable provider for such services furnished
16 to an individual during a period;

17 “(ii) not make payment under sub-
18 paragraph (A) if such payment would be
19 duplicative of payment that is otherwise
20 made under this title for such services
21 (such as in the case of hospice care or
22 home health services); and

23 “(iii) not require that an annual
24 wellness visit (as defined in section
25 1861(hhh)) or an initial preventive phys-

1 ical examination (as defined in section
2 1861(wv)) be furnished as a condition of
3 payment for such management services.”.

4 **SEC. 5. ENSURING ACCURATE VALUATION OF SERVICES**

5 **UNDER THE PHYSICIAN FEE SCHEDULE.**

6 (a) **AUTHORITY TO COLLECT AND USE INFORMA-**
7 **TION ON PHYSICIANS’ SERVICES IN THE DETERMINATION**
8 **OF RELATIVE VALUES.—**

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

13 “(M) **AUTHORITY TO COLLECT AND USE**
14 **INFORMATION ON PHYSICIANS’ SERVICES IN**
15 **THE DETERMINATION OF RELATIVE VALUES.—**

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

1 “(ii) USE OF INFORMATION.—Not-
2 withstanding any other provision of law,
3 subject to clause (v), the Secretary may
4 (as the Secretary determines appropriate)
5 use information collected or obtained pur-
6 suant to clause (i) in the determination of
7 relative values for services under this sec-
8 tion.

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

13 “(I) Time involved in furnishing
14 services.

15 “(II) Amounts and types of prac-
16 tice expense inputs involved with fur-
17 nishing services.

18 “(III) Prices (net of any dis-
19 counts) for practice expense inputs,
20 which may include paid invoice prices
21 or other documentation or records.

22 “(IV) Overhead and accounting
23 information for practices of physicians
24 and other suppliers.

1 “(V) Any other element that
2 would improve the valuation of serv-
3 ices under this section.

4 “(iv) INFORMATION COLLECTION
5 MECHANISMS.—Information may be col-
6 lected or obtained pursuant to this sub-
7 paragraph from any or all of the following:

8 “(I) Surveys of physicians, other
9 suppliers, providers of services, manu-
10 facturers, and vendors.

11 “(II) Surgical logs, billing sys-
12 tems, or other practice or facility
13 records.

14 “(III) Electronic health records.

15 “(IV) Any other mechanism de-
16 termined appropriate by the Sec-
17 retary.

18 “(v) TRANSPARENCY OF USE OF IN-
19 FORMATION.—

20 “(I) IN GENERAL.—Subject to
21 subclauses (II) and (III), if the Sec-
22 retary uses information collected or
23 obtained under this subparagraph in
24 the determination of relative values
25 under this subsection, the Secretary

1 shall disclose the information source
2 and discuss the use of such informa-
3 tion in such determination of relative
4 values through notice and comment
5 rulemaking.

6 “(II) THRESHOLDS FOR USE.—
7 The Secretary may establish thresh-
8 olds in order to use such information,
9 including the exclusion of information
10 collected or obtained from eligible pro-
11 fessionals who use very high resources
12 (as determined by the Secretary) in
13 furnishing a service.

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

23 “(vi) INCENTIVE TO PARTICIPATE.—
24 The Secretary may provide for such pay-
25 ments under this part to an eligible profes-

1 sional that submits such solicited informa-
2 tion under this subparagraph as the Sec-
3 retary determines appropriate in order to
4 compensate such eligible professional for
5 such submission. Such payments shall be
6 provided in a form and manner specified
7 by the Secretary.

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

12 “(viii) DEFINITION OF ELIGIBLE PRO-
13 FESSIONAL.—In this subparagraph, the
14 term ‘eligible professional’ has the meaning
15 given such term in subsection (k)(3)(B).

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

1 under the preceding sentence for a fiscal
2 year shall be available until expended.”.

3 (2) LIMITATION ON REVIEW.—Section
4 1848(i)(1) of the Social Security Act (42 U.S.C.
5 1395w-4(i)(1)) is amended—

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

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

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

12 “(F) the collection and use of information
13 in the determination of relative values under
14 subsection (c)(2)(M).”.

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

21 “(N) AUTHORITY FOR ALTERNATIVE AP-
22 PROACHES TO ESTABLISHING PRACTICE EX-
23 PENSE RELATIVE VALUES.—The Secretary may
24 establish or adjust practice expense relative val-
25 ues under this subsection using cost, charge, or

1 other data from suppliers or providers of serv-
2 ices, including information collected or obtained
3 under subparagraph (M).”.

4 (c) REVISED AND EXPANDED IDENTIFICATION OF
5 POTENTIALLY MISVALUED CODES.—Section
6 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.
7 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

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

15 “(I) Codes that have experienced
16 the fastest growth.

17 “(II) Codes that have experi-
18 enced substantial changes in practice
19 expenses.

20 “(III) Codes that describe new
21 technologies or services within an ap-
22 propriate time period (such as 3
23 years) after the relative values are ini-
24 tially established for such codes.

1 “(IV) Codes which are multiple
2 codes that are frequently billed in con-
3 junction with furnishing a single serv-
4 ice.

5 “(V) Codes with low relative val-
6 ues, particularly those that are often
7 billed multiple times for a single treat-
8 ment.

9 “(VI) Codes that have not been
10 subject to review since implementation
11 of the fee schedule.

12 “(VII) Codes that account for
13 the majority of spending under the
14 physician fee schedule.

15 “(VIII) Codes for services that
16 have experienced a substantial change
17 in the hospital length of stay or proce-
18 dure time.

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

22 “(X) Codes for which there is a
23 significant difference in payment for
24 the same service between different
25 sites of service.

1 “(XI) Codes for which there may
2 be anomalies in relative values within
3 a family of codes.

4 “(XII) Codes for services where
5 there may be efficiencies when a serv-
6 ice is furnished at the same time as
7 other services.

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

10 “(XIV) Codes with high practice
11 expense relative value units.

12 “(XV) Codes with high cost sup-
13 plies.

14 “(XVI) Codes as determined ap-
15 propriate by the Secretary.”

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

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

22 “(O) TARGET FOR RELATIVE VALUE AD-
23 JUSTMENTS FOR MISVALUED SERVICES.—With
24 respect to fee schedules established for each of
25 2015 through 2018, the following shall apply:

1 “(i) DETERMINATION OF NET REDUC-
2 TION IN EXPENDITURES.—For each year,
3 the Secretary shall determine the esti-
4 mated net reduction in expenditures under
5 the fee schedule under this section with re-
6 spect to the year as a result of adjust-
7 ments to the relative values established
8 under this paragraph for misvalued codes.

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

17 “(I) reduced expenditures attrib-
18 utable to such adjustments shall be
19 redistributed for the year in a budget
20 neutral manner in accordance with
21 subparagraph (B)(ii)(II); and

22 “(II) the amount by which such
23 reduced expenditures exceeds the tar-
24 get for the year shall be treated as a
25 reduction in expenditures described in

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

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

16 “(iv) TARGET RECAPTURE AMOUNT.—
17 For purposes of clause (iii), the target re-
18 capture amount is, with respect to a year,
19 an amount equal to the difference be-
20 tween—

21 “(I) the target for the year; and

22 “(II) the estimated net reduction
23 in expenditures determined under
24 clause (i) for the year.

1 “(v) TARGET.—For purposes of this
2 subparagraph, with respect to a year, the
3 target is calculated as 0.5 percent of the
4 estimated amount of expenditures under
5 the fee schedule under this section for the
6 year.”.

7 (2) CONFORMING AMENDMENT.—Section
8 1848(e)(2)(B)(v) of the Social Security Act (42
9 U.S.C. 1395w–4(e)(2)(B)(v)) is amended by adding
10 at the end the following new subclause:

11 “(VIII) REDUCTIONS FOR
12 MISVALUED SERVICES IF TARGET NOT
13 MET.—Effective for fee schedules be-
14 ginning with 2015, reduced expendi-
15 tures attributable to the application of
16 the target recapture amount described
17 in subparagraph (O)(iii).”.

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

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

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

1 schedules established beginning with 2015, if the
2 total relative value units for a service for a year
3 would otherwise be decreased by an estimated
4 amount equal to or greater than 20 percent as com-
5 pared to the total relative value units for the pre-
6 vious year, the applicable adjustments in work, prac-
7 tice expense, and malpractice relative value units
8 shall be phased-in over a 2-year period.”.

9 (2) CONFORMING AMENDMENTS.—Section
10 1848(e)(2) of the Social Security Act (42 U.S.C.
11 1395w-4(e)(2)) is amended—

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

15 (B) in subparagraph (K)(iii)(VI)—

16 (i) by striking “provisions of subpara-
17 graph (B)(ii)(II)” and inserting “provi-
18 sions of subparagraph (B)(ii)(II) and para-
19 graph (7)”; and

20 (ii) by striking “under subparagraph
21 (B)(ii)(II)” and inserting “under subpara-
22 graph (B)(ii)(I)”.

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

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

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

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

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

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

19 (2) REPORT.—Not later than 1 year after the
20 date of the enactment of this Act, the Comptroller
21 General shall submit to Congress a report containing
22 the results of the study conducted under paragraph
23 (1).

24 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-
25 ITIES.—

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

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

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

14 “(i) Each Metropolitan Statistical
15 Area (each in this paragraph referred to as
16 an ‘MSA’), as defined by the Director of
17 the Office of Management and Budget as
18 of December 31 of the previous year, shall
19 be a fee schedule area.

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

23 “(B) TRANSITION FOR MSAS PREVIOUSLY
24 IN REST-OF-STATE PAYMENT LOCALITY OR IN
25 LOCALITY 3.—

1 “(i) IN GENERAL.—For services fur-
2 nished in California during a year begin-
3 ning with 2017 and ending with 2021 in
4 an MSA in a transition area (as defined in
5 subparagraph (D)), subject to subpara-
6 graph (C), the geographic index values to
7 be applied under this subsection for such
8 year shall be equal to the sum of the fol-
9 lowing:

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

19 “(II) MSA-BASED COMPO-
20 NENT.—The MSA-based weighting
21 factor (described in clause (iii)) for
22 such year multiplied by the geographic
23 index values computed for the fee
24 schedule area under subparagraph (A)

1 for the year (determined without re-
2 gard to this subparagraph).

3 “(ii) OLD WEIGHTING FACTOR.—The
4 old weighting factor described in this
5 clause—

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

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

11 “(iii) MSA-BASED WEIGHTING FAC-
12 TOR.—The MSA-based weighting factor
13 described in this clause for a year is 1
14 minus the old weighting factor under
15 clause (ii) for that year.

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

1 “(D) TRANSITION AREA DEFINED.—In
2 this paragraph, the term ‘transition area’
3 means each of the following fee schedule areas
4 for 2013:

5 “(i) The rest-of-State payment local-
6 ity.

7 “(ii) Payment locality 3.

8 “(E) REFERENCES TO FEE SCHEDULE
9 AREAS.—Effective for services furnished on or
10 after January 1, 2017, for California, any ref-
11 erence in this section to a fee schedule area
12 shall be deemed a reference to a fee schedule
13 area established in accordance with this para-
14 graph.”.

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

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

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

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

1 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR
2 CERTAIN IMAGING SERVICES.—

3 “(1) PROGRAM ESTABLISHED.—

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

13 “(B) APPROPRIATE USE CRITERIA DE-
14 FINED.—In this subsection, the term ‘appro-
15 priate use criteria’ means criteria to assist or-
16 dering professionals and furnishing profes-
17 sionals in making the most appropriate treat-
18 ment decision for a specific clinical condition.
19 To the extent feasible, such criteria shall be evi-
20 dence-based.

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

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

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

7 “(iii) one or more of such mechanisms
8 is available free of charge.

9 “(D) APPLICABLE SETTING DEFINED.—In
10 this subsection, the term ‘applicable setting’
11 means a physician’s office, a hospital outpatient
12 department (including an emergency depart-
13 ment), an ambulatory surgical center, and any
14 other outpatient setting determined appropriate
15 by the Secretary.

16 “(E) ORDERING PROFESSIONAL DE-
17 FINED.—In this subsection, the term ‘ordering
18 professional’ means a physician (as defined in
19 section 1861(r)) or a practitioner described in
20 section 1842(b)(18)(C) who orders an applica-
21 ble imaging service for an individual.

22 “(F) FURNISHING PROFESSIONAL DE-
23 FINED.—In this subsection, the term ‘fur-
24 nishing professional’ means a physician (as de-
25 fined in section 1861(r)) or a practitioner de-

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

3 “(2) ESTABLISHMENT OF APPLICABLE APPRO-
4 PRIATE USE CRITERIA.—

5 “(A) IN GENERAL.—Not later than No-
6 vember 15, 2015, the Secretary shall through
7 rulemaking, and in consultation with physi-
8 cians, practitioners, and other stakeholders,
9 specify applicable appropriate use criteria for
10 applicable imaging services from among appro-
11 priate use criteria developed or endorsed by na-
12 tional professional medical specialty societies or
13 other entities.

14 “(B) CONSIDERATIONS.—In specifying ap-
15 plicable appropriate use criteria under subpara-
16 graph (A), the Secretary shall take into account
17 whether the criteria—

18 “(i) have stakeholder consensus;

19 “(ii) have been determined to be sci-
20 entifically valid and are evidence based;
21 and

22 “(iii) are in the public domain.

23 “(C) REVISIONS.—The Secretary shall pe-
24 riodically update and revise (as appropriate)

1 such specification of applicable appropriate use
2 criteria.

3 “(D) TREATMENT OF MULTIPLE APPLICA-
4 BLE APPROPRIATE USE CRITERIA.—In the case
5 where the Secretary determines that more than
6 one appropriate use criteria applies with respect
7 to an applicable imaging service, the Secretary
8 shall specify one or more applicable appropriate
9 use criteria under this paragraph for the serv-
10 ice.

11 “(3) MECHANISMS FOR CONSULTATION WITH
12 APPLICABLE APPROPRIATE USE CRITERIA.—

13 “(A) IDENTIFICATION OF MECHANISMS TO
14 CONSULT WITH APPLICABLE APPROPRIATE USE
15 CRITERIA.—

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

22 “(ii) CONSULTATION.—The Secretary
23 shall consult with physicians, practitioners,
24 and other stakeholders in specifying mech-
25 anisms under this paragraph.

1 “(iii) INCLUSION OF CERTAIN MECHA-
2 NISMS.—Mechanisms specified under this
3 paragraph may include any or all of the
4 following that meet the requirements de-
5 scribed in subparagraph (B)(ii):

6 “(I) Use of clinical decision sup-
7 port modules in certified EHR tech-
8 nology (as defined in section
9 1848(o)(4)).

10 “(II) Use of private sector clin-
11 ical decision support mechanisms that
12 are independent from certified EHR
13 technology, which may include use of
14 clinical decision support mechanisms
15 available from medical specialty orga-
16 nizations.

17 “(III) Use of a clinical decision
18 support mechanism established by the
19 Secretary.

20 “(B) QUALIFIED CLINICAL DECISION SUP-
21 PORT MECHANISMS.—

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

1 the Secretary determines meets the re-
2 quirements described in clause (ii).

3 “(ii) REQUIREMENTS.—The require-
4 ments described in this clause are the fol-
5 lowing:

6 “(I) The mechanism makes avail-
7 able to the ordering professional appli-
8 cable appropriate use criteria specified
9 under paragraph (2) and the sup-
10 porting documentation for the applica-
11 ble imaging service ordered.

12 “(II) In the case where there are
13 more than one applicable appropriate
14 use criteria specified under such para-
15 graph for an applicable imaging serv-
16 ice, the mechanism indicates the cri-
17 teria that it uses for the service.

18 “(III) The mechanism determines
19 the extent to which an applicable im-
20 aging service ordered is consistent
21 with the applicable appropriate use
22 criteria so specified.

23 “(IV) The mechanism generates
24 and provides to the ordering profes-
25 sional a certification or documentation

1 that documents that the qualified clin-
2 ical decision support mechanism was
3 consulted by the ordering professional.

4 “(V) The mechanism is updated
5 on a timely basis to reflect revisions
6 to the specification of applicable ap-
7 propriate use criteria under such
8 paragraph.

9 “(VI) The mechanism meets pri-
10 vacy and security standards under ap-
11 plicable provisions of law.

12 “(VII) The mechanism performs
13 such other functions as specified by
14 the Secretary, which may include a re-
15 quirement to provide aggregate feed-
16 back to the ordering professional.

17 “(C) LIST OF MECHANISMS FOR CON-
18 SULTATION WITH APPLICABLE APPROPRIATE
19 USE CRITERIA.—

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

24 “(ii) PERIODIC UPDATING OF LIST.—
25 The Secretary shall periodically update the

1 list of qualified clinical decision support
2 mechanisms specified under this para-
3 graph.

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

6 “(A) CONSULTATION BY ORDERING PRO-
7 FESSIONAL.—Beginning with January 1, 2017,
8 subject to subparagraph (C), with respect to an
9 applicable imaging service ordered by an order-
10 ing professional that would be furnished in an
11 applicable setting and paid for under an appli-
12 cable payment system (as defined in subpara-
13 graph (D)), an ordering professional shall—

14 “(i) consult with a qualified decision
15 support mechanism listed under paragraph
16 (3)(C); and

17 “(ii) provide to the furnishing profes-
18 sional the information described in clauses
19 (i) through (iii) of subparagraph (B).

20 “(B) REPORTING BY FURNISHING PROFES-
21 SIONAL.—Beginning with January 1, 2017,
22 subject to subparagraph (C), with respect to an
23 applicable imaging service furnished in an ap-
24 plicable setting and paid for under an applica-
25 ble payment system (as defined in subpara-

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

4 “(i) Information about which qualified
5 clinical decision support mechanism was
6 consulted by the ordering professional for
7 the service.

8 “(ii) Information regarding—

9 “(I) whether the service ordered
10 would adhere to the applicable appro-
11 priate use criteria specified under
12 paragraph (2);

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

15 “(III) whether such criteria was
16 not applicable to the service ordered.

17 “(iii) The national provider identifier
18 of the ordering professional (if different
19 from the furnishing professional).

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

23 “(i) EMERGENCY SERVICES.—An ap-
24 plicable imaging service ordered for an in-

1 dividual with an emergency medical condi-
2 tion (as defined in section 1867(e)(1)).

3 “(ii) INPATIENT SERVICES.—An appli-
4 cable imaging service ordered for an inpa-
5 tient and for which payment is made under
6 part A.

7 “(iii) ALTERNATIVE PAYMENT MOD-
8 ELS.—An applicable imaging service or-
9 dered by an ordering professional with re-
10 spect to an individual attributed to an al-
11 ternative payment model (as defined in
12 section 1833(z)(3)(C)).

13 “(iv) SIGNIFICANT HARDSHIP.—An
14 applicable imaging service ordered by an
15 ordering professional who the Secretary
16 may, on a case-by-case basis, exempt from
17 the application of such provisions if the
18 Secretary determines, subject to annual re-
19 newal, that consultation with applicable ap-
20 propriate use criteria would result in a sig-
21 nificant hardship, such as in the case of a
22 professional who practices in a rural area
23 without sufficient Internet access.

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

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

6 “(ii) The prospective payment system
7 for hospital outpatient department services
8 under section 1833(t).

9 “(iii) The ambulatory surgical center
10 payment systems under section 1833(i).

11 “(5) IDENTIFICATION OF OUTLIER ORDERING
12 PROFESSIONALS.—

13 “(A) IN GENERAL.—With respect to appli-
14 cable imaging services furnished beginning with
15 2017, the Secretary shall determine, on a peri-
16 odic basis (which may be annually), ordering
17 professionals who are outlier ordering profes-
18 sionals.

19 “(B) OUTLIER ORDERING PROFES-
20 SIONALS.—The determination of an outlier or-
21 dering professional shall—

22 “(i) be based on low adherence to ap-
23 plicable appropriate use criteria specified
24 under paragraph (2), which may be based

1 on comparison to other ordering profes-
2 sionals; and

3 “(ii) include data for ordering profes-
4 sionals for whom prior authorization under
5 paragraph (6)(A) applies.

6 “(C) USE OF TWO YEARS OF DATA.—The
7 Secretary shall use two years of data to identify
8 outlier ordering professionals under this para-
9 graph.

10 “(D) CONSULTATION WITH STAKE-
11 HOLDERS.—The Secretary shall consult with
12 physicians, practitioners and other stakeholders
13 in developing methods to identify outlier order-
14 ing professionals under this paragraph.

15 “(6) PRIOR AUTHORIZATION FOR ORDERING
16 PROFESSIONALS WHO ARE OUTLIERS.—

17 “(A) IN GENERAL.—Beginning January 1,
18 2020, subject to paragraph (4)(C), with respect
19 to services furnished during a year, the Sec-
20 retary shall, for a period determined appro-
21 priate by the Secretary, apply prior authoriza-
22 tion for applicable imaging services that are or-
23 dered by an outlier ordering professional identi-
24 fied under paragraph (5).

1 “(B) FUNDING.—For purposes of carrying
2 out this paragraph, the Secretary shall provide
3 for the transfer, from the Federal Supple-
4 mentary Medical Insurance Trust Fund under
5 section 1841, of \$5,000,000 to the Centers for
6 Medicare & Medicaid Services Program Man-
7 agement Account for each of fiscal years 2019
8 through 2021. Amounts transferred under the
9 preceding sentence shall remain available until
10 expended.”.

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

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

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

1 “(q) ESTABLISHMENT OF APPROPRIATE USE PRO-
2 GRAM FOR OTHER PART B SERVICES.—

3 “(1) ESTABLISHMENT.—

4 “(A) IN GENERAL.—The Secretary may es-
5 tablish an appropriate use program for services
6 under this part (other than applicable imaging
7 services under subsection (p)) using a process
8 similar to the process under such subsection.

9 “(B) REQUIREMENTS.—In determining
10 whether to establish a program under subpara-
11 graph (A), the Secretary shall take into consid-
12 eration—

13 “(i) the implementation of appropriate
14 use criteria for applicable imaging services
15 under subsection (p); and

16 “(ii) the report under paragraph (2).

17 “(C) INPUT FROM STAKEHOLDERS IN AD-
18 VANCE OF RULEMAKING.—Before issuing a no-
19 tice of proposed rulemaking to establish a pro-
20 gram under subparagraph (A), the Secretary
21 shall issue an advance notice of proposed rule-
22 making.

23 “(2) REPORT ON EXPERIENCE OF IMAGING AP-
24 PROPRIATE USE CRITERIA PROGRAM.—Not later
25 than 18 months after the date of the enactment of

1 this subsection, the Comptroller General of the
2 United States shall submit to Congress a report that
3 includes a description of the extent to which appro-
4 priate use criteria could be used for other services
5 under this part, such as radiation therapy and clin-
6 ical diagnostic laboratory services.”.

7 **SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH**
8 **ACCESS TO INFORMATION ON PHYSICIANS’**
9 **SERVICES.**

10 (a) TRANSFERRING FREESTANDING PHYSICIAN COM-
11 PARE PROVISION TO THE SOCIAL SECURITY ACT.—

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

17 (2) CONFORMING REDESIGNATIONS.—Section
18 1848(t) of the Social Security Act (42 U.S.C.
19 1395w–4(t)), as transferred and redesignated by
20 paragraph (1), is further amended—

21 (A) by striking the subsection heading and
22 inserting the following new subsection heading:
23 “PUBLIC REPORTING OF PERFORMANCE AND
24 OTHER INFORMATION ON PHYSICIAN COM-
25 PARE”;

1 (B) by redesignating subsections (a)
2 through (i) as paragraphs (1) through (9), re-
3 spectively, and indenting appropriately;

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

6 (i) by redesignating paragraphs (1)
7 and (2) as subparagraphs (A) and (B), re-
8 spectively, and indenting appropriately;

9 (ii) in subparagraph (B), as redesi-
10 gnated by clause (i), by redesignating sub-
11 paragraphs (A) through (G) as clauses (i)
12 through (vii), respectively, and indenting
13 appropriately;

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

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

23 (3) CONFORMING AMENDMENTS.—Section
24 1848(t) of the Social Security Act (42 U.S.C.

1 1395w-4(t)), as amended by paragraph (2), is fur-
2 ther amended—

3 (A) in paragraph (1)—

4 (i) in subparagraph (A)—

5 (I) by striking “the Medicare
6 program under section 1866(j) of the
7 Social Security Act (42 U.S.C.
8 1395cc(j))” and inserting “the pro-
9 gram under this title under section
10 1866(j)”; and

11 (II) by striking “of such Act (42
12 U.S.C. 1395w-4)”; and

13 (ii) in subparagraph (B), in the mat-
14 ter preceding clause (i)—

15 (I) by striking “subsection (c)”
16 and inserting “paragraph (3)”;

17 (II) by striking “the Medicare
18 program under such section 1866(j)”
19 and inserting “the program under this
20 title under section 1866(j)”; and

21 (III) by striking “this section”
22 and inserting “this subsection”;

23 (B) in paragraph (2)—

- 1 (i) in the matter preceding subpara-
2 graph (A), by striking “subsection (a)(2)”
3 and inserting “paragraph (1)(B)”;
- 4 (ii) in subparagraph (D), by striking
5 “the Medicare program” and inserting
6 “the program under this title”; and
- 7 (iii) in each of subparagraphs (F) and
8 (G), by striking “this section” and insert-
9 ing “this subsection”;
- 10 (C) in paragraph (3), by striking “this sec-
11 tion” and inserting “this subsection”;
- 12 (D) in paragraph (4)—
- 13 (i) by striking “of the Social Security
14 Act, as added by section 3014 of this Act”;
15 and
- 16 (ii) by striking “this section” and in-
17 serting “this subsection”;
- 18 (E) in paragraph (5)—
- 19 (i) by striking “this subsection (a)(2)”
20 and inserting “paragraph (1)(B)”;
- 21 (ii) by striking “(Public Law 110–
22 275)”;
- 23 (F) in paragraph (6), by striking “sub-
24 section (a)(1)” and inserting “paragraph
25 (1)(A)”;

1 (G) in paragraph (7)—

2 (i) by striking “subsection (f)” and in-
3 sserting “paragraph (6)”; and

4 (ii) by striking “title XVIII of the So-
5 cial Security Act” and inserting “this
6 title”;

7 (H) in paragraph (8)—

8 (i) by striking “subparagraphs (A)
9 through (G) of subsection (a)(2)” and in-
10 sserting “clauses (i) through (vii) of para-
11 graph (1)(B)”;

12 (ii) by striking “title XVIII of the So-
13 cial Security Act” and inserting “this
14 title”; and

15 (iii) by striking “such title” and in-
16 sserting “this title”; and

17 (I) in paragraph (9)—

18 (i) in the matter preceding subpara-
19 graph (8), by striking “this section” and
20 inserting “this subsection”;

21 (ii) in subparagraph (A), by striking
22 “of the Social Security Act (42 U.S.C.
23 1395w-4)”;

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

1 (iv) in subparagraph C), by striking
2 “subsection (a)(1)” and inserting “para-
3 graph (1)(A)”;

4 (v) by striking subparagraph (D).

5 (b) PUBLIC AVAILABILITY OF MEDICARE DATA.—
6 Section 1848(t) of the Social Security Act (42 U.S.C.
7 1395w-4(t)), as amended by subsection (a), is further
8 amended—

9 (1) by redesignating paragraph (9) as para-
10 graph (10);

11 (2) by inserting after paragraph (8) the fol-
12 lowing new paragraph:

13 “(9) PUBLIC AVAILABILITY OF ELIGIBLE PRO-
14 FESSIONAL CLAIMS DATA.—

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

19 “(B) INFORMATION DESCRIBED.—The fol-
20 lowing information, with respect to an eligible
21 professional, is described in this subparagraph:

22 “(i) Information on the number of
23 services furnished by the eligible profes-
24 sional, which may include information on

1 the most frequent services furnished or
2 groupings of services.

3 “(ii) Information on submitted
4 charges and payments for services under
5 this part.

6 “(iii) A unique identifier for the eligi-
7 ble professional that is available to the
8 public, such as a national provider identi-
9 fier.

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

13 “(i) The specialty or type of the eligi-
14 ble professional.

15 “(ii) Characteristics of the services
16 furnished, such as volume or groupings of
17 services.

18 “(iii) The location of the eligible pro-
19 fessional.

20 “(D) DISCLOSURE.—The information
21 made available under this paragraph shall indi-
22 cate, where appropriate, that publicized infor-
23 mation may not be representative of the eligible
24 professional’s entire patient population, the va-
25 riety of services furnished by the eligible profes-

1 sional, or the health conditions of individuals
2 treated.

3 “(E) IMPLEMENTATION.—

4 “(i) INITIAL IMPLEMENTATION.—Physi-
5 sician Compare shall include the informa-
6 tion described in subparagraph (B)—

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

9 “(II) with respect to other eligi-
10 ble professionals, by not later than
11 July 1, 2016.

12 “(ii) ANNUAL UPDATING.—The infor-
13 mation made available under this para-
14 graph shall be updated on Physician Com-
15 pare not less frequently than on an annual
16 basis.

17 “(F) OPPORTUNITY TO REVIEW AND SUB-
18 MIT CORRECTIONS.—The Secretary shall pro-
19 vide for an opportunity for an eligible profes-
20 sional to review, and submit corrections for, the
21 information to be made public with respect to
22 the eligible professional under this paragraph
23 prior to such information being made public.”;
24 and

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

4 **SEC. 8. EXPANDING CLAIMS DATA AVAILABILITY TO IM-**
5 **PROVE CARE.**

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

10 “(5) EXPANSION OF USES OF CLAIMS DATA BY
11 QUALIFIED ENTITIES.—

12 “(A) EXPANSION.—To the extent con-
13 sistent with applicable information, privacy, se-
14 curity, and disclosure laws, beginning July 1,
15 2014, notwithstanding paragraph (4)(B) (other
16 than clause (iii) of such paragraph) and the
17 second sentence of paragraph (4)(D), a quali-
18 fied entity may, as determined appropriate by
19 the Secretary, do any or all of the following:

20 “(i)(I) Use the combined data de-
21 scribed in paragraph (4)(B)(iii) to conduct
22 analyses, other than for reports described
23 in paragraph (4), for entities described in
24 subparagraph (B) for non-public uses, as
25 determined appropriate by the Secretary,

1 such as for the purposes described in sub-
2 clause (II).

3 “(II) The purposes described in this
4 subclause are assisting providers of serv-
5 ices and suppliers in developing and par-
6 ticipating in quality and patient care im-
7 provement activities (including developing
8 new models of care), population health
9 management, and disease monitoring, and
10 the purposes described in subparagraph
11 (C).

12 “(ii) Provide or sell such analyses to
13 entities described in subparagraph (B).

14 “(iii) Provide entities described in
15 clauses (i), (ii), (v), and (vi) of subpara-
16 graph (B) with access to the combined
17 data described in paragraph (4)(B)(iii)
18 through a qualified data enclave (as de-
19 fined in subparagraph (F)) that is main-
20 tained by the qualified entity in order for
21 entities described in such clauses to con-
22 duct analyses for non-public uses, such as
23 for the purposes described in clause (i)(II).

24 “(B) ENTITIES DESCRIBED.—For the pur-
25 pose of subparagraph (A) clauses (i) and (ii),

1 the entities described in this subparagraph are
2 the following:

3 “(i) A provider of services.

4 “(ii) A supplier.

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

9 “(iv) A health insurance issuer (as de-
10 fined in section 2791 of the Public Health
11 Service Act) that provides data under
12 paragraph (4)(B)(iii).

13 “(v) A medical society or hospital as-
14 sociation.

15 “(vi) Other entities approved by the
16 Secretary (other than an employer (as so
17 defined) and a health insurance issuer (as
18 so defined)).

19 “(C) LIMITATION WITH RESPECT TO EM-
20 PLOYERS.—Any analyses provided or sold under
21 this paragraph to an employer (as so defined)
22 may only be used by such employer for pur-
23 poses of providing health insurance to employ-
24 ees and retirees of the employer.

1 “(D) PROTECTION OF PATIENT IDENTI-
2 FICATION.—

3 “(i) IN GENERAL.—Except as pro-
4 vided in clause (ii), an analysis provided or
5 sold under this paragraph shall not contain
6 information that individually identifies a
7 patient.

8 “(ii) INFORMATION ON PATIENTS OF
9 THE PROVIDER OF SERVICES OR SUP-
10 PLIER.—An analysis that is provided or
11 sold under this paragraph to a provider of
12 services or supplier may contain data that
13 individually identifies a patient of such
14 provider or supplier but only with respect
15 to items and services furnished by such
16 provider or supplier to such patient.

17 “(iii) OPPORTUNITY FOR PROVIDERS
18 OF SERVICES AND SUPPLIERS TO RE-
19 VIEW.—Prior to a qualified entity pro-
20 viding or selling an analysis under this
21 paragraph to an entity described in sub-
22 paragraph (B), to the extent that such
23 analysis would individually identify a pro-
24 vider of services or supplier who is not
25 being provided or sold such analysis, such

1 qualified entity shall provide an oppor-
2 tunity for such provider or supplier to re-
3 view and submit corrections to such anal-
4 ysis.

5 “(E) NO REDISCLOSURE.—An entity de-
6 scribed in subparagraph (B) that is provided or
7 sold an analysis under this paragraph shall not
8 redisclose or make public such an analysis.

9 “(F) REQUIREMENTS FOR A QUALIFIED
10 DATA ENCLAVE.—

11 “(i) DEFINITION.—For purposes of
12 this paragraph, the term ‘qualified data
13 enclave’ means a data enclave that the
14 Secretary determines meets the following:

15 “(I) The data enclave is a web-
16 based portal or comparable mecha-
17 nism.

18 “(II) Subject to the requirements
19 described in clause (ii) and such other
20 requirements as the Secretary may
21 specify, the data enclave is capable of
22 providing access to the combined data
23 described in subparagraph (A)(iii).

1 “(ii) ENCLAVE ACCESS REQUIRE-
2 MENTS.—The requirements described in
3 this clause are the following:

4 “(I) A qualified data enclave
5 shall preclude any entity that obtains
6 access to the data from removing or
7 extracting the data from such enclave.

8 “(II) Subject to the succeeding
9 sentence, the enclave shall preclude
10 access to data that individually identi-
11 fies a patient, including data on the
12 patient’s name and date of birth and
13 such other data as the Secretary shall
14 specify. Such data enclave may pro-
15 vide providers of services and sup-
16 pliers with access to such individually
17 identifiable patient data but only with
18 respect to items and services fur-
19 nished by such provider or supplier to
20 such patient.

21 “(III) Access to data in the en-
22 clave shall not be provided to any en-
23 tity unless the qualified entity and the
24 entity have entered into a data use
25 agreement, the terms of which contain

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

4 “(G) ANNUAL REPORTS.—Any qualified
5 entity that provides or sells analyses pursuant
6 to subparagraph (A)(ii) or provides access to a
7 qualified data enclave pursuant to subpara-
8 graph (A)(iii) shall annually submit to the Sec-
9 retary a report that includes—

10 “(i) a summary of the analyses pro-
11 vided or sold, including the number of such
12 analyses, the number of purchasers of such
13 analyses, and the total amount of fees re-
14 ceived for such analyses;

15 “(ii) a description of the topics and
16 purposes of such analyses;

17 “(iii) information on the entities who
18 obtained access to the qualified data en-
19 clave, the uses of the data, and the total
20 amount of fees received for providing such
21 access; and

22 “(iv) other information determined
23 appropriate by the Secretary.”.

1 (b) EXPANSION OF DATA AVAILABLE TO QUALIFIED
2 ENTITIES.—Section 1874(e) of the Social Security Act
3 (42 U.S.C. 1395kk(e)) is amended—

4 (1) in the subsection heading, by striking
5 “Medicare”; and

6 (2) in paragraph (3)—

7 (A) by inserting after the first sentence the
8 following new sentence: “Effective July 1,
9 2014, if the Secretary determines appropriate,
10 the data described in this paragraph may also
11 include standardized extracts (as determined by
12 the Secretary) of claims data under titles XIX
13 and XXI for assistance provided under such ti-
14 tles for one or more specified geographic areas
15 and time periods requested by a qualified enti-
16 ty.”; and

17 (B) in the last sentence, by inserting “or
18 under titles XIX or XXI” before the period at
19 the end.

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

1 “(vi) ACCESS TO MEDICARE DATA TO
2 FACILITATE QUALITY IMPROVEMENT.—

3 “(I) IN GENERAL.—To the extent
4 consistent with applicable information,
5 privacy, security, and disclosure laws,
6 and subject to other requirements as
7 the Secretary may specify, beginning
8 July 1, 2014, the Secretary shall, if
9 requested by a qualified clinical data
10 registry under this subparagraph, sub-
11 ject to subclauses (II) and (III), pro-
12 vide data as described in section
13 1874(e)(3) (in a form and manner de-
14 termined to be appropriate) to such
15 registry for purposes of linking such
16 data with clinical data and performing
17 analyses and research to support qual-
18 ity improvement or patient safety.

19 “(II) PROTECTION.—A qualified
20 clinical data registry may not publicly
21 report any data made available under
22 subclause (I) (or any analyses or re-
23 search described in such subclause)
24 that individually identifies a provider
25 of services, supplier, or individual un-

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

4 “(III) FEE.—The data described
5 in subclause (I) shall be made avail-
6 able to qualified clinical data reg-
7 istries at a fee equal to the cost of
8 making such data available. Any fee
9 collected pursuant to the preceding
10 sentence shall be deposited in the
11 Centers for Medicare & Medicaid
12 Services Program Management Ac-
13 count.”.

14 (d) REVISION OF PLACEMENT OF FEES.—Section
15 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
16 1395kk(e)(4)(A)) is amended, in the second sentence—

17 (1) by inserting “, for periods prior to July 1,
18 2014,” after “deposited”; and

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

1 **SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER**
2 **PROVISIONS.**

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

5 (1) **INDEFINITE, CONTINUING AUTOMATIC EX-**
6 **TENSION OF OPT OUT ELECTION.—**

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

10 (i) in subparagraph (B)(ii), by strik-
11 ing “during the 2-year period beginning on
12 the date the affidavit is signed” and insert-
13 ing “during the applicable 2-year period
14 (as defined in subparagraph (D))”;

15 (ii) in subparagraph (C), by striking
16 “during the 2-year period described in sub-
17 paragraph (B)(ii)” and inserting “during
18 the applicable 2-year period”; and

19 (iii) by adding at the end the fol-
20 lowing new subparagraph:

21 “(D) **APPLICABLE 2-YEAR PERIODS FOR**
22 **EFFECTIVENESS OF AFFIDAVITS.—**In this sub-
23 section, the term ‘applicable 2-year period’
24 means, with respect to an affidavit of a physi-
25 cian or practitioner under subparagraph (B),
26 the 2-year period beginning on the date the af-

1 fidavit is signed and includes each subsequent
2 2-year period unless the physician or practi-
3 tioner involved provides notice to the Secretary
4 (in a form and manner specified by the Sec-
5 retary), not later than 30 days before the end
6 of the previous 2-year period, that the physician
7 or practitioner does not want to extend the ap-
8 plication of the affidavit for such subsequent 2-
9 year period.”.

10 (B) EFFECTIVE DATE.—The amendments
11 made by subparagraph (A) shall apply to affi-
12 davits entered into on or after the date that is
13 60 days after the date of the enactment of this
14 Act.

15 (2) PUBLIC AVAILABILITY OF INFORMATION ON
16 OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section
17 1802(b) of the Social Security Act (42 U.S.C.
18 1395a(b)) is amended—

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

21 “(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—
22 The term ‘opt-out physician or practitioner’ means
23 a physician or practitioner who has in effect an affi-
24 davit under paragraph (3)(B).”;

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

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

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

7 “(A) IN GENERAL.—Beginning not later
8 than February 1, 2015, the Secretary shall
9 make publicly available through an appropriate
10 publicly accessible website of the Department of
11 Health and Human Services information on the
12 number and characteristics of opt-out physi-
13 cians and practitioners and shall update such
14 information on such website not less often than
15 annually.

16 “(B) INFORMATION TO BE INCLUDED.—
17 The information to be made available under
18 subparagraph (A) shall include at least the fol-
19 lowing with respect to opt-out physicians and
20 practitioners:

21 “(i) Their number.

22 “(ii) Their physician or professional
23 specialty or other designation.

24 “(iii) Their geographic distribution.

1 “(iv) The timing of their becoming
2 opt-out physicians and practitioners, rel-
3 ative to when they first entered practice
4 and with respect to applicable 2-year peri-
5 ods.

6 “(v) The proportion of such physi-
7 cians and practitioners who billed for
8 emergency or urgent care services.”.

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

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services (in this subsection referred to as
13 the “Secretary”) shall establish and implement a
14 demonstration project (in this section referred to as
15 the “demonstration project”) under title XVIII of
16 the Social Security Act to provide that payments for
17 services under such title furnished by non-partici-
18 pating physicians (as defined in section 1861(r)(1)
19 of the Social Security Act (42 U.S.C. 1395x(r)(1)))
20 to individuals entitled to benefits under part A or
21 enrolled under part B of such title are paid directly
22 to such physicians. The Secretary shall carry out the
23 demonstration project in a geographic area that is a
24 statistically significant area no larger than a State.

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

8 (3) TIMETABLE FOR IMPLEMENTATION.—

9 (A) DEMONSTRATION START DATE.—The
10 demonstration project shall apply with respect
11 to services furnished beginning on January 1,
12 2015.

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

17 (4) REPORT.—Not later than 18 months after
18 the date of the conclusion of the demonstration
19 project, the Secretary shall submit to Congress a re-
20 port analyzing the impact of the demonstration
21 project. Such report shall include an analysis of the
22 impact, if any, of the demonstration project upon
23 the—

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

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

4 (B) percentage of claims submitted by and
5 payments made to physicians in the demonstra-
6 tion that are unassigned and a comparison of
7 unassigned claims and payments by non-partici-
8 pating physicians in the previous year;

9 (C) percentage and number of the physi-
10 cians in the demonstration by specialty designa-
11 tion; and

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

16 (5) BENEFICIARY NOTICE.—

17 (A) NOTICE BY SECRETARY TO BENE-
18 FICIARIES.—The Secretary shall notify individ-
19 uals entitled to benefits under part A or en-
20 rolled under part B of title XVIII of the Social
21 Security Act in the geographic area in which
22 the demonstration project is conducted of the
23 implications of physician participation in the
24 demonstration project.

1 (B) NOTICE BY PHYSICIANS TO PA-
2 TIENTS.—A physician who elects to participate
3 in the demonstration project shall notify indi-
4 viduals to whom the physician furnishes serv-
5 ices for which payment will be provided under
6 the demonstration project of such election. Such
7 notification shall be provided prior to the provi-
8 sion of service and include a notification, with
9 respect to each such individual, that—

10 (i) the right of the individual to pay-
11 ment is being reassigned to the physician;

12 (ii) payment for services furnished by
13 the physician to such individual will be
14 made directly to the physician; and

15 (iii) the individual is responsible for
16 the remaining amount, which may be high-
17 er than would be the case if the physician
18 participated in the Medicare program.

19 (c) GAINSHARING STUDY AND REPORT.—Not later
20 than 6 months after the date of the enactment of this Act,
21 the Secretary of Health and Human Services, in consulta-
22 tion with the Inspector General of the Department of
23 Health and Human Services, shall submit to Congress a
24 report with legislative recommendations to amend existing
25 fraud and abuse laws, through exceptions, safe harbors,

1 or other narrowly targeted provisions, to permit
2 gainsharing or similar arrangements between physicians
3 and hospitals that improve care while reducing waste and
4 increasing efficiency. The report shall—

5 (1) consider whether such provisions should
6 apply to ownership interests, compensation arrange-
7 ments, or other relationships; and

8 (2) describe how the recommendations address
9 accountability, transparency, and quality, including
10 how best to limit inducements to stint on care, dis-
11 charge patients prematurely, or otherwise reduce or
12 limit medically necessary care; and

13 (3) consider whether a portion of any savings
14 generated by such arrangements should accrue to
15 the Medicare program under title XVIII of the So-
16 cial Security Act.

17 (d) PROMOTING INTEROPERABILITY OF ELECTRONIC
18 HEALTH RECORD SYSTEMS.—

19 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-
20 SPREAD EHR INTEROPERABILITY.—

21 (A) OBJECTIVE.—As a consequence of a
22 significant Federal investment in the implemen-
23 tation of health information technology through
24 the Medicare EHR incentive programs, Con-
25 gress declares it a national objective to achieve

1 widespread and nationwide exchange of health
2 information through interoperable certified
3 EHR technology by December 31, 2019.

4 (B) DEFINITIONS.—In this paragraph:

5 (i) WIDESPREAD INTEROPER-
6 ABILITY.—The term “widespread inter-
7 operability” means nationwide interoper-
8 ability between certified EHR technology
9 systems employed by meaningful EHR
10 users under the Medicare EHR incentive
11 programs and other clinicians and health
12 care providers.

13 (ii) INTEROPERABILITY.—The term
14 “interoperability” means the ability of two
15 or more health information systems or
16 components to exchange clinical and other
17 information and to use the information
18 that has been exchanged using common
19 standards as to provide access to longitu-
20 dinal information for health care providers
21 in order to facilitate coordinated care and
22 improved patient outcomes.

23 (C) ESTABLISHMENT OF METRICS.—Not
24 later than December 31, 2015, and in consulta-
25 tion with stakeholders, the Secretary shall es-

1 tabish metrics to be used to determine if and
2 to the extent that the objective described in
3 subparagraph (A) has been achieved.

4 (D) RECOMMENDATIONS IF OBJECTIVE
5 NOT ACHIEVED.—If the Secretary of Health
6 and Human Services determines that the objec-
7 tive described in subparagraph (A) has not been
8 achieved by December 31, 2017, then the Sec-
9 retary shall submit to Congress a report, by not
10 later than December 31, 2018, that identifies
11 barriers to such objective and recommends ac-
12 tions that the Federal Government can take to
13 achieve such objective. Such recommended ac-
14 tions may include recommendations—

15 (i) to adjust payments for meaningful
16 EHR users under the Medicare EHR in-
17 centive programs; and

18 (ii) for criteria for decertifying cer-
19 tified EHR technology products.

20 (2) PREVENTING BLOCKING THE SHARING OF
21 INFORMATION.—

22 (A) FOR MEANINGFUL EHR PROFES-
23 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-
24 cial Security Act (42 U.S.C. 1395w-
25 4(o)(2)(A)(ii)) is amended by inserting before

1 the period at the end the following: “, and the
2 professional demonstrates (through a process
3 specified by the Secretary, such as the use of an
4 attestation similar to that required in the
5 health information technology donation safe
6 harbor established under regulations under sec-
7 tion 1128B(b)(3)(E)) that the professional has
8 not and will not take any deliberate action to
9 limit or restrict the use, compatibility, or inter-
10 operability of the certified EHR technology”.

11 (B) FOR MEANINGFUL EHR HOSPITALS.—
12 Section 1886(n)(3)(A)(ii) of the Social Security
13 Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amend-
14 ed by inserting before the period at the end the
15 following: “, and the hospital demonstrates
16 (through a process specified by the Secretary,
17 such as the use of an attestation referred to in
18 section 1848(o)(2)(A)(ii)) that the hospital has
19 not and will not take any deliberate action to
20 limit or restrict the use, compatibility, or inter-
21 operability of the certified EHR technology”.

22 (C) EFFECTIVE DATE.—The amendments
23 made by this subsection shall apply to meaning-
24 ful EHR users as of the date that is 6 months
25 after the date of the enactment of this Act.

1 (3) STUDY AND REPORT ON THE FEASIBILITY
2 OF ESTABLISHING A WEBSITE TO COMPARE CER-
3 TIFIED EHR TECHNOLOGY PRODUCTS.—

4 (A) STUDY.—The Secretary shall conduct
5 a study to examine the feasibility of estab-
6 lishing a website (in this subsection referred to
7 as the “website”) that includes aggregated re-
8 sults of surveys of meaningful EHR users on
9 the functionality of certified EHR technology
10 products to enable such users to directly com-
11 pare the functionality and other features of
12 such products. Such information may be made
13 available through contracts with physician, hos-
14 pital, or other organizations that maintain such
15 comparative information.

16 (B) REPORT.—Not later than 1 year after
17 the date of the enactment of this Act, the Sec-
18 retary shall submit to Congress a report on the
19 website. The report shall include information on
20 the benefits and resources of such a website.

21 (4) DEFINITIONS.—In this subsection:

22 (A) The term “certified EHR technology”
23 has the meaning given such term in section
24 1848(o)(4) of the Social Security Act (42
25 U.S.C. 1395w-4(o)(4)).

1 (B) The term “meaningful EHR hospital”
2 means an eligible hospital (as defined in section
3 1886(n)(6)(A) of the Social Security Act (42
4 U.S.C. 1395ww(n)(6)(A)) that is a meaningful
5 EHR user.

6 (C) The term “meaningful EHR profes-
7 sional” means an eligible professional (as de-
8 fined in section 1848(o)(5)(C) of the Social Se-
9 curity Act (42 U.S.C. 1395w-4(o)(5)(C)) who
10 is a meaningful EHR user.

11 (D) The term “meaningful EHR user” has
12 the meaning given such term under the Medi-
13 care EHR incentive programs.

14 (E) The term “Medicare EHR incentive
15 programs” means the incentive programs under
16 section 1848(o), subsections (l) and (m) of sec-
17 tion 1853, and section 1886(n) of the Social
18 Security Act (42 U.S.C. 1395w-4(o), 1395w-
19 23, 1395ww(n)).

20 (F) The term “Secretary” means the Sec-
21 retary of Health and Human Services.

22 (e) GAO STUDY AND REPORT ON THE USE OF TELE-
23 HEALTH UNDER FEDERAL PROGRAMS.—

24 (1) STUDY.—The Comptroller General of the
25 United States shall conduct a study on the following:

1 (A) How the definition of telehealth across
2 various Federal programs and federal efforts
3 can inform the use of telehealth in the Medicare
4 program under title XVIII of the Social Secu-
5 rity Act (42 U.S.C. 1395 et seq.).

6 (B) Issues that can facilitate or inhibit the
7 use of telehealth under the Medicare program
8 under such title, including oversight and profes-
9 sional licensure, changing technology, privacy
10 and security, infrastructure requirements, and
11 varying needs across urban and rural areas.

12 (C) Potential implications of greater use of
13 telehealth with respect to payment and delivery
14 system transformations under the Medicare
15 program under such title XVIII and the Med-
16 icaid program under title XIX of such Act (42
17 U.S.C. 1396 et seq.).

18 (D) How the Centers for Medicare & Med-
19 icaid Services conducts oversight of payments
20 made under the Medicare program under such
21 title XVIII to providers for telehealth services.

22 (2) REPORT.—Not later than 24 months after
23 the date of the enactment of this Act, the Comp-
24 troller General shall submit to Congress a report
25 containing the results of the study conducted under

1 paragraph (1), together with recommendations for
2 such legislation and administrative action as the
3 Comptroller General determines appropriate.

4 (f) RULE OF CONSTRUCTION REGARDING HEALTH
5 CARE PROVIDER STANDARDS OF CARE.—

6 (1) IN GENERAL.—The development, recogni-
7 tion, or implementation of any guideline or other
8 standard under any Federal health care provision
9 shall not be construed to establish the standard of
10 care or duty of care owed by a health care provider
11 to a patient in any medical malpractice or medical
12 product liability action or claim.

13 (2) DEFINITIONS.—For purposes of this sub-
14 section:

15 (A) The term “Federal health care provi-
16 sion” means any provision of the Patient Pro-
17 tection and Affordable Care Act (Public Law
18 111–148), title I and subtitle B of title III of
19 the Health Care and Education Reconciliation
20 Act of 2010 (Public Law 111–152), and titles
21 XVIII and XIX of the Social Security Act.

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

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

4 (ii) required to be so licensed, reg-
5 istered, or certified but that is exempted
6 by other statute or regulation.

7 (C) The term “medical malpractice or
8 medical liability action or claim” means a med-
9 ical malpractice action or claim (as defined in
10 section 431(7) of the Health Care Quality Im-
11 provement Act of 1986 (42 U.S.C. 11151(7)))
12 and includes a liability action or claim relating
13 to a health care provider’s prescription or provi-
14 sion of a drug, device, or biological product (as
15 such terms are defined in section 201 of the
16 Federal Food, Drug, and Cosmetic Act or sec-
17 tion 351 of the Public Health Service Act).

18 (D) The term “State” includes the District
19 of Columbia, Puerto Rico, and any other com-
20 monwealth, possession, or territory of the
21 United States.

22 (3) NO PREEMPTION.—No provision of the Pa-
23 tient Protection and Affordable Care Act (Public
24 Law 111–148), title I or subtitle B of title III of the
25 Health Care and Education Reconciliation Act of

1 2010 (Public Law 111–152), or title XVIII or XIX
2 of the Social Security Act shall be construed to pre-
3 empt any State or common law governing medical
4 professional or medical product liability actions or
5 claims.

