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(Original Signature of Member)

113TH CONGRESS
1ST SESSION

H. R. 2810

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

IN THE HOUSE OF REPRESENTATIVES

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

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Patient Access and Quality Improvement Act of 2013''.

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

SEC. 2. REFORM OF SUSTAINABLE GROWTH RATE (SGR) AND MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

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

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

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting ''or a subsequent paragraph or section 1848A'' after ''paragraph (4)''; and

(ii) in paragraph (4)—

(I) in the heading, by striking ''YEARS BEGINNING WITH 2001'' and inserting ''2001, 2002, AND 2003''; and

(II) in subparagraph (A), by striking ''a year beginning with 2001'' and inserting ''2001, 2002, and 2003''; and

(B) in subsection (f)—

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

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

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

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

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

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

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

''(16) UPDATE BEGINNING WITH 2019.—

''(A) IN GENERAL.—Subject to subparagraph (B), the update to the single conversion

factor established in paragraph (1)(C) for each year beginning with 2019 shall be 0.5 percent.

''(B) ADJUSTMENT.—In the case of an eligible professional (as defined in subsection (k)(3)) who does not have a payment arrangement described in section 1848A(a) in effect, the update under subparagraph (A) for a year beginning with 2019 shall be adjusted by the applicable quality adjustment determined under subsection (q)(3) for the year involved.''; and

(B) in subsection (i)(1)—

(i) by striking ''and'' at the end of subparagraph (D);

(ii) by striking the period at the end of subparagraph (E) and inserting '', and''; and

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

''(F) the implementation of subsection (q).''.

(2) ENHANCING PHYSICIAN QUALITY REPORTING SYSTEM TO SUPPORT QUALITY UPDATE INCENTIVE PROGRAM.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (k)(1), in the first sentence, by inserting ''and, if applicable, clinical practice improvement activities,'' after ''quality measures'';

(B) in subsection (k)(2)—

(i) in subparagraph (C)—

(I) in the subparagraph heading, by striking ''AND SUBSEQUENT YEARS'' and inserting ''THROUGH 2018''; and

(II) in clause (i), by inserting ''(before 2019)'' after ''subsequent year'';

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

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

''(D) FOR 2019 AND SUBSEQUENT YEARS.—For purposes of reporting data on quality measures and, as applicable clinical practice improvement activities, for covered professional services furnished during the performance period (as defined in subsection (q)(2)(B)) with respect to 2019 and the performance period with respect to each subsequent year, sub-

ject to subsection (q)(1)(D), the quality measures and clinical practice improvement activities specified under this paragraph shall be, with respect to an eligible professional, the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under paragraph (9)(F) applicable to the peer cohort of such provider and year involved.''; and

(iv) in subparagraph (E), as redesignated by subparagraph (B)(ii) of this paragraph, by striking ''AND SUBSEQUENT YEARS'';

(C) in subsection (k)(3)—

(i) in the paragraph heading, by striking ''COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED'' and inserting ''DEFINITIONS''; and

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

''(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—The term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improv-

ing clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

''(D) ELIGIBLE PROFESSIONAL ORGANIZATION.—The term 'eligible professional organization' means a professional organization that is recognized by the American Board of Medical Specialties, American Osteopathic Association, American Board of Physician Specialties, or an equivalent certification board.

''(E) PEER COHORT.—The term 'peer cohort' means a peer cohort identified on the list under paragraph (9)(B), as updated under clause (ii) of such paragraph.'';

(D) in subsection (k)(7), by striking '' and the application of paragraphs (4) and (5)'' and inserting '', the application of paragraphs (4) and (5), and the implementation of paragraph (9)'';

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

''(9) ESTABLISHMENT OF FINAL CORE MEASURE SETS.—

''(A) IN GENERAL.—Under the system under this subsection—

''(i) for each peer cohort identified under subparagraph (B) and in accordance with this paragraph, there shall be published a final core measure set under subparagraph (F), which shall consist of quality measures and may also consist of clinical practice improvement activities, with respect to which eligible professionals shall, subject to subsection (m)(3)(C), be assessed for purposes of determining, for years beginning with 2019, the quality adjustment under subsection (q)(3) applicable to such professionals; and

''(ii) each eligible professional shall self-identify, in accordance with subparagraph (B), within such a peer cohort for purposes of such assessments.

''(B) PEER COHORTS.—The Secretary shall identify (and publish a list of) peer cohorts by which eligible professionals shall self-identify for purposes of this subsection and subsection (q) with respect to a performance period (as defined in subsection (q)(2)(B)) for a year beginning with 2019. For purposes of this subsection and subsection (q), the Secretary shall

develop one or more peer cohorts for multispecialty groups, each of which shall be included as a peer cohort under this subparagraph. Such self-identification will be made through such a process and at such time as specified under the system under this subsection. Such list—

''(i) shall include, as peer cohorts, provider specialties defined by the American Board of Medical Specialties or equivalent certification boards and such other cohorts as established under this section in order to capture classifications of providers across eligible professional organizations and other practice areas, groupings, or categories; and

''(ii) shall be updated from time to time.

''(C) QUALITY MEASURES FOR CORE MEASURE SETS.—

''(i) DEVELOPMENT.—Under the system under this subsection there shall be established a process for the development of quality measures under this subparagraph for purposes of potential inclusion of such

measures in core measure sets under this paragraph. Under such process—

"(I) there shall be coordination, to the extent possible, across organizations developing such measures;

"(II) eligible professional organizations and other relevant stakeholders may submit best practices and clinical practice guidelines for the development of quality measures that address quality domains (as defined under clause (ii)) for potential inclusion in such core measure sets;

"(III) there is encouraged to be developed, as appropriate, meaningful outcome measures (or quality of life measures in cases for which outcomes may not be a valid measurement), functional status measures, and patient experience measures; and

"(IV) measures developed under this clause shall be developed, to the extent possible, in accordance with best practices and clinical practice guidelines.

''(ii) QUALITY DOMAINS.—For purposes of this paragraph, the term 'quality domains' means at least the following domains:

''(I) Clinical care.

''(II) Safety.

''(III) Care coordination.

''(IV) Patient and caregiver experience.

''(V) Population health and prevention.

''(D) PROCESS FOR ESTABLISHING CORE MEASURE SETS.—

''(i) IN GENERAL.—Under the system under this subsection, for purposes of subparagraph (A), there shall be established a process to approve final core measure sets under this paragraph for peer cohorts. Each such final core measure set shall be composed of quality measures (and, as applicable, clinical practice improvement activities) with respect to which eligible professionals within such peer cohort shall report under this subsection and be assessed

under subsection (q). Such process shall provide—

''(I) for the establishment of criteria, which shall be made publicly available before the request is made under clause (ii), for selecting such measures and activities for potential inclusion in such a final core measure set; and

''(II) that all peer cohorts, and to the extent practicable all quality domains, are addressed by measures and, as applicable, clinical practice improvement activities selected to be included in a core measure set under this paragraph, which may include through the use of such a measure or clinical practice improvement activity that addresses more than one such domain or cohort.

''(ii) SOLICITATION OF PUBLIC INPUT ON QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Under the process established under clause (i), relevant eligible professional organiza-

tions and other relevant stakeholders shall be requested to identify and submit quality measures and clinical practice improvement activities (as defined in paragraph (3)(C)) for selection under this paragraph. For purposes of the previous sentence, measures and activities may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

''(E) CORE MEASURE SETS.—

''(i) IN GENERAL.—Under the process established under subparagraph (D)(i), the Secretary—

''(I) shall select, from quality measures described in clause (ii) applicable to a peer cohort, quality measures to be included in a core measure set for such cohort;

''(II) shall, to the extent there are insufficient quality measures applicable to a peer cohort to address one or more applicable quality domains, select to be included in a core

measure set for such cohort such clinical practice improvement activities described in clause (ii)(IV) as are needed and available to sufficiently address such an applicable domain with respect to such peer cohort; and

''(III) may select, to the extent determined appropriate, any additional clinical practice improvement activities described in clause (ii)(IV) applicable to a peer cohort to be included in a core measure set for such cohort.

Activities selected under this paragraph shall be selected with consideration of best practices and clinical practice guidelines identified under subparagraph (C)(i)(II).

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

"(I) a measure endorsed by a consensus-based entity;

"(II) a measure developed under paragraph (2)(C) or a measure otherwise applied or developed for a similar purpose under this section;

"(III) a measure developed under subparagraph (C); or

"(IV) a measure or activity submitted under subparagraph (D)(ii).

A measure or activity may be selected under this subparagraph, regardless of whether such measure or activity was previously published in a proposed rule. A measure so selected shall be evidence-based but (other than a measure described in subclause (I)) shall not be required to be consensus-based.

"(iii) TRANSPARENCY.—Before publishing in a final regulation a core measure set under clause (i) as a final core measure set under subparagraph (F), the Secretary shall—

"(I) submit for publication in applicable specialty-appropriate peer-re-

viewed journals such core measure set under clause (i) and the method for developing and selecting measures within such set, including clinical and other data supporting such measures, and, as applicable, the method for selecting clinical practice improvement activities included within such set; and

''(II) regardless of whether or not the core measure set or method is published in such a journal under subclause (I), provide for notice of the proposed regulation in the Federal Register, including with respect to the applicable methods and data described in subclause (I), and a period for public comment thereon.

''(F) FINAL CORE MEASURE SETS.—Not later than November 15 of the year prior to the first day of a performance period, the Secretary shall publish a final regulation in the Federal Register that includes a final core measure set (and the applicable methods and data described

in subparagraph (E)(iii)(I)) for each peer cohort to be applied for such performance period.

''(G) PERIODIC REVIEW AND UPDATES.—

''(i) IN GENERAL.—In carrying out this paragraph, under the system under this subsection, there shall periodically be reviewed—

''(I) the quality measures and clinical practice improvement activities selected for inclusion in final core measure sets under this paragraph for each year such measures and activities are to be applied under this subsection or subsection (q) to ensure that such measures and activities continue to meet the conditions applicable to such measures and activities for such selection; and

''(II) the final core measure sets published under subparagraph (F) for each year such sets are to be applied to peer cohorts of eligible professionals to ensure that each applicable set continues to meet the conditions

applicable to such sets before being so published.

''(ii) COLLABORATION WITH STAKEHOLDERS.—In carrying out clause (i), relevant eligible professional organizations and other relevant stakeholders may identify and submit updates to quality measures and clinical practice improvement activities selected under this paragraph for inclusion in final core measure sets as well as any additional quality measures and clinical practice improvement activities. Not later than November 15 of the year prior to the first day of a performance period, submissions under this clause shall be reviewed.

''(iii) ADDITIONAL, AND UPDATES TO, MEASURES AND ACTIVITIES.—Based on the review conducted under this subparagraph for a period, as needed, there shall be—

''(I) selected additional, and updates to, quality measures and clinical practice improvement activities selected under this paragraph for poten-

tial inclusion in final core measure sets in the same manner such quality measures and clinical practice improvement activities are selected under this paragraph for such potential inclusion;

''(II) removed, from final core measure sets, quality measures and clinical practice improvement activities that are no longer meaningful; and

''(III) updated final core measure sets published under subparagraph (F) in the same manner as such sets are approved under such subparagraph.

For purposes of this subsection and subsection (q), a final core measure set, as updated under this subparagraph, shall be treated in the same manner as a final core measure set published under subparagraph (F).

''(iv) TRANSPARENCY.—

''(I) NOTIFICATION REQUIRED FOR CERTAIN UPDATES.—In the case of an update under subclause (II) or

(III) of clause (iii) that adds, materially changes, or removes a measure or activity from a measure set, such update shall not apply under this subsection or subsection (q) unless notification of such update is made available to applicable eligible professionals.

''(II) PUBLIC AVAILABILITY OF UPDATED FINAL CORE MEASURE SETS.—Subparagraph (E)(iii) shall apply with respect to measure sets updated under subclause (II) or (III) of clause (iii) in the same manner as such subparagraph applies to applicable core measure sets under subparagraph (E).

''(H) COORDINATION WITH EXISTING PROGRAMS.—The development and selection of quality measures and clinical practice improvement activities under this paragraph shall, as appropriate, be coordinated with the development and selection of existing measures and requirements, such as the development of the Physician Compare Website under subsection

(m)(5)(G) and the application of resource use management under subsection (n). To the extent feasible, such measures and activities shall align with measures used by other payers and with measures and activities in use under other programs in order to streamline the process of such development and selection under this paragraph. The Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of certified EHR technology.

''(I) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations (as defined in paragraph (3)(D)) and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this paragraph.

''(J) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the development or selection of measures under this paragraph.''; and

(F) in subsection (m)(3)(C)(i), by adding at the end the following new sentence: ''Such process shall, beginning for 2019, treat eligible professionals in such a group practice as reporting on measures for purposes of application of subsections (q) and (a)(8)(A)(iii) if, in lieu of reporting measures under subsection (k)(2)(D), the group practice reports measures determined appropriate by the Secretary.''.

(3) ESTABLISHMENT OF QUALITY UPDATE INCENTIVE PROGRAM.—

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

''(q) QUALITY UPDATE INCENTIVE PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish an eligible professional quality update incentive program (in this section referred to as the 'quality update incentive program') under which—

''(i) there is developed and applied, in accordance with paragraph (2), appropriate methodologies for assessing the per-

formance of eligible professionals with respect to quality measures and clinical practice improvement activities included within the final core measure sets published under subsection (k)(9)(F) applicable to the peer cohorts of such providers;

''(ii) there is applied, consistent with the system under subsection (k), methods for collecting information needed for such assessments (which shall involve the minimum amount of administrative burden required to ensure reliable results); and

''(iii) the applicable update adjustments under paragraph (3) are determined by such assessments.

''(B) DEFINITIONS.—

''(i) ELIGIBLE PROFESSIONAL.—In this subsection, the term 'eligible professional' has the meaning given such term in subsection (k)(3), except that such term shall not include a professional who has a payment arrangement described in section 1848A(a)(1) in effect.

''(ii) PEER COHORTS; CLINICAL PRACTICE IMPROVEMENT ACTIVITIES; ELIGIBLE

PROFESSIONAL ORGANIZATIONS.—In this subsection, the terms 'peer cohort', 'clinical practice improvement activity', and 'eligible professional organization' have the meanings given such terms in subsection (k)(3).

''(C) CONSULTATION WITH ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subsection.

''(D) APPLICATION AT GROUP PRACTICE LEVEL.—The Secretary shall establish a process, consistent with subsection (m)(3)(C), under which the provisions of this subsection are applied to eligible professionals in a group practice if the group practice reports measures determined appropriate by the Secretary under such subsection.

''(E) COORDINATION WITH EXISTING PROGRAMS.—The application of measures and clinical practice improvement activities and assessment of performance under this subsection shall, as appropriate, be coordinated with the

application of measures and assessment of performance under other provisions of this section.

''(2) ASSESSING PERFORMANCE WITH RESPECT TO FINAL CORE MEASURE SETS FOR APPLICABLE PEER COHORTS.—

''(A) ESTABLISHMENT OF METHODS FOR ASSESSMENT.—

''(i) IN GENERAL.—Under the quality update incentive program, the Secretary shall—

''(I) establish one or more methods, applicable with respect to a performance period, to assess (using a scoring scale of 0 to 100) the performance of an eligible professional with respect to, subject to paragraph (1)(D), quality measures and clinical practice improvement activities included within the final core measure set published under subsection (k)(9)(F) applicable for the period to the peer cohort in which the provider self-identified under subsection (k)(9)(B) for such period; and

''(II) subject to paragraph (1)(D), compute a composite score for such provider for such performance period with respect to the measures and activities included within such final core measure set.

''(ii) METHODS.—Such methods shall, with respect to an eligible professional, provide that the performance of such professional shall, subject to paragraph (1)(D), be assessed for a performance period with respect to the quality measures and clinical practice improvement activities within the final core measure set for such period for the peer cohort of such professional and on which information is collected from such professional.

''(iii) WEIGHTING OF MEASURES.—Such a method may provide for the assignment of different scoring weights or, as appropriate, other factors—

''(I) for quality measures and clinical practice improvement activities;

''(II) based on the type or category of measure or activity; and

''(III) based on the extent to which a quality measure or clinical practice improvement activity meaningfully assesses quality.

''(iv) RISK ADJUSTMENT.—Such a method shall provide for appropriate risk adjustments.

''(v) INCORPORATION OF OTHER METHODS OF MEASURING PHYSICIAN QUALITY.—In establishing such methods, there shall be, as appropriate, incorporated comparable methods of measurement from physician quality incentive programs under this subsection.

''(B) PERFORMANCE PERIOD.—There shall be established a period (in this subsection referred to as a 'performance period'), with respect to a year (beginning with 2019) for which the quality adjustment is applied under paragraph (3), to assess performance on quality measures and clinical practice improvement activities. Each such performance period shall be a period of 12 consecutive months and shall end

as close as possible to the beginning of the year for which such adjustment is applied.

''(3) QUALITY ADJUSTMENT TAKING INTO ACCOUNT QUALITY ASSESSMENTS.—

''(A) QUALITY ADJUSTMENT.—For purposes of subsection (d)(16), if the composite score computed under paragraph (2)(A) for an eligible professional for a year (beginning with 2019) is—

''(i) a score of 67 or higher, the quality adjustment under this paragraph for the eligible professional and year is 1 percentage point;

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

''(iii) a score below 34, the quality adjustment under this paragraph for the eligible professional and year is -1 percentage point.

''(B) NO EFFECT ON SUBSEQUENT YEARS' QUALITY ADJUSTMENTS.—Each such quality adjustment shall be made each year without re-

gard to the update adjustment for a previous year under this paragraph.

''(4) TRANSITION FOR NEW ELIGIBLE PROFESSIONALS.—In the case of a physician, practitioner, or other supplier that during a performance period, with respect to a year for which a quality adjustment is applied under paragraph (3), first becomes an eligible professional (and had not previously submitted claims under this title as a person, as an entity, or as part of a physician group or under a different billing number or tax identifier), the quality adjustment under this subsection applicable to such physician, practitioner, or supplier—

''(A) for such year, with respect to such first performance period, shall be zero; and

''(B) for a year, with respect to a subsequent performance period, shall be the quality adjustment that would otherwise be applied under this subsection.

''(5) FEEDBACK.—

''(A) FEEDBACK.—

''(i) ONGOING FEEDBACK.—Under the process under subsection (m)(5)(H), there shall be provided, as real time as possible,

but at least quarterly, to each eligible professional feedback—

"(I) on the performance of such provider with respect to quality measures and clinical practice improvement activities within the final core measure set published under subsection (k)(9)(F) for the applicable performance period and the peer cohort of such professional; and

"(II) to assess the progress of such professional under the quality update incentive program with respect to a performance period for a year.

"(ii) USE OF REGISTRIES AND OTHER MECHANISMS.—Feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided and based on performance received through the use of such registry, and to the extent that an eligible professional chooses not to participate in such a registry for such pur-

poses, be provided through other similar mechanisms that allow for the provision of such feedback and receipt of such performance information.

''(B) DATA MECHANISM.—Under the quality update incentive program, there shall be developed an electronic interactive eligible professional mechanism through which such a professional may receive performance data, including data with respect to performance on the measures and activities developed and selected under this section. Such mechanism shall be developed in consultation with private payers and health insurance issuers (as defined in section 2791(b)(2) of the Public Health Service Act) as appropriate.

''(C) TRANSFER OF FUNDS.—The Secretary shall provide for the transfer of $100,000,000 from the Federal Supplementary Medical Insurance Trust Fund established in section 1841 to the Center for Medicare & Medicaid Services Program Management Account to support such efforts to develop the infrastructure as necessary to carry out subsection (k)(9) and this subsection and for purposes of section

1889(h). Such funds shall be so transferred on the date of the enactment of this subsection and shall remain available until expended.''.

(B) INCENTIVE TO REPORT UNDER QUALITY UPDATE INCENTIVE PROGRAM.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking ''With respect to'' and inserting ''Subject to clause (iii), with respect to''; and

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

''(iii) APPLICATION TO ELIGIBLE PROFESSIONALS NOT REPORTING.—With respect to covered professional services (as defined in subsection (k)(3)) furnished by an eligible professional during 2019 or any subsequent year, if the eligible professional does not submit data for the performance period (as defined in subsection (q)(2)(B)) with respect to such year on, subject to subsection (q)(1)(D), the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under subsection (k)(9)(F) ap-

plicable to the peer cohort of such provider, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to 95 percent (in lieu of the applicable percent) of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph). The Secretary shall develop a minimum per year caseload threshold, with respect to eligible professionals, and the previous sentence shall not apply to eligible professionals with a caseload for a year below such threshold for such year.''.

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

''(h) QUALITY UPDATE INCENTIVE PROGRAM.—Under this section, information shall be disseminated to educate and assist eligible professionals (as defined in sec-

tion 1848(k)(3)) about the quality update incentive program under section 1848(q) and quality measures under section 1848(k)(9) through multiple approaches, including a national dissemination strategy and outreach by medicare contractors.''.

(4) CONFORMING AMENDMENTS.—

(A) TREATMENT OF SATISFACTORILY REPORTING PQRS MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by striking ''For 2014 and subsequent years'' and inserting ''For each of 2014 through 2018''.

(B) COORDINATING ENHANCED PQRS REPORTING WITH EHR.—Section 1848(o)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(B)(iii)) is amended by striking ''subsection (k)(2)(C)'' and inserting ''subparagraph (C) or (D) of subsection (k)(2)''.

(C) COORDINATING PQRS REPORTING PERIOD WITH QUALITY UPDATE INCENTIVE PROGRAM PERFORMANCE PERIOD.—Section

1848(m)(6)(C) of the Social Security Act (42 U.S.C. 1395w–4(m)(6)(C)) is amended—

(i) in clause (i), by striking ''and (iii)'' and inserting '', (iii), and (iv)''; and

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

''(iv) COORDINATION WITH QUALITY UPDATE INCENTIVE PROGRAM.—For 2019 and each subsequent year the reporting period shall be coordinated with the performance period under subsection (q)(2)(B).''.

(D) COORDINATING EHR REPORTING WITH QUALITY UPDATE INCENTIVE PROGRAM PERFORMANCE PERIOD.—Section 1848(o)(5)(B) of the Social Security Act (42 U.S.C. 1395w–4(o)(5)(B)) is amended by adding at the end the following: ''Beginning for 2019, the EHR reporting period shall be coordinated with the performance period under subsection (q)(2)(B).''.

(c) ADVANCING ALTERNATIVE PAYMENT MODELS.—

(1) IN GENERAL.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395w–4 et seq.) is amended by adding at the end the following new section:

"SEC. 1848A. ADVANCING ALTERNATIVE PAYMENT MODELS.

"(a) PAYMENT MODEL CHOICE PROGRAM.—Payment for covered professional services (as defined in section 1848(k)) that are furnished by an eligible professional (as defined in such section) under an Alternative Payment Model specified on the list under subsection (h) (in this section referred to as an 'eligible APM') shall be made under this title in accordance with the payment arrangement under such model. In applying the previous sentence, such a professional with such a payment arrangement in effect, shall be deemed for purposes of section 1848(a)(8) to be satisfactorily submitting data on quality measures for such covered professional services.

"(b) PROCESS FOR IMPLEMENTING ELIGIBLE APMS.—

"(1) IN GENERAL.—For purposes of subsection (a) and in accordance with this section, the Secretary shall establish a process under which—

"(A) a contract is entered into, in accordance with paragraph (2).

"(B) proposals for potential Alternative Payment Models are submitted in accordance with subsection (c);

"(C) Alternative Payment Models so proposed are recommended, in accordance with subsection (d), for evaluation, including through

the demonstration program under subsection (e), and approval under subsection (f);

''(D) applicable Alternative Payment Models are evaluated under such demonstration program;

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

''(F) a comprehensive list of all eligible APMs is made publicly available, in accordance with subsection (h), for application under subsection (a).

''(2) CONTRACT WITH APM CONTRACTING ENTITY.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the Secretary shall identify and have in effect a contract with an independent entity that has appropriate expertise to carry out the functions applicable to such entity under this section. Such entity shall be referred to in this section as the 'APM contracting entity'.

''(B) TIMING FOR FIRST CONTRACT.—As soon as practicable, but not later than one year after the date of the enactment of this section,

the Secretary shall enter into the first contract under subparagraph (A).

''(C) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)) shall be used to enter into a contract under subparagraph (A).

''(c) SUBMISSION OF PROPOSED ALTERNATIVE PAYMENT MODELS.—Beginning not later than 90 days after the date the Secretary enters into a contract under subsection (b)(2) with the APM contracting entity, physicians, eligible professional organizations, health care provider organizations, and other entities may submit to the APM contracting entity proposals for Alternative Payment Models for application under this section. Such a proposal of a model shall include suggestions for measures to be used under subsection (e)(1)(B) for purposes of evaluating such model. In reviewing submissions under this subsection for purposes of making recommendations under subsection (d)(1), the contracting entity shall focus on submissions for such models that are intended to improve care coordination and quality for patients through modifying the manner in which physicians and other providers are paid under this title.

''(d) RECOMMENDATION BY APM CONTRACTING ENTITY OF PROPOSED MODELS.—

''(1) RECOMMENDATION.—

''(A) IN GENERAL.—Under the process under subsection (b), the APM contracting entity shall at least annually recommend to the Secretary—

''(i) based on the criteria described in subparagraph (B), Alternative Payment Models submitted under subsection (c) to be evaluated through a demonstration program under subsection (e); and

''(ii) based on the criteria described in subparagraph (C), Alternative Payment Models submitted under subsection (c) for purposes of implementation under subsection (f), without evaluation through such a demonstration program.

Such a recommendation may be made with respect to a model for which a waiver would be required under paragraph (2).

''(B) CRITERIA FOR RECOMMENDING MODELS FOR DEMONSTRATION.—The APM contracting entity shall make a recommendation under subparagraph (A)(i), with respect to an

Alternative Payment Model, only if the entity determines that the model satisfies each of the following criteria:

''(i) The model has been supported by meaningful clinical and non-clinical data, with respect to a sufficient population sample, that indicates the model would be successful at addressing each of the abilities described in clause (v).

''(ii) (I) In the case of a model that has already been evaluated and supported by data with respect to a population of individuals enrolled under this part, if the model were evaluated under the demonstration under subsection (e) such a population would represent a sufficient number of individuals enrolled under this part to ensure meaningful evaluation.

''(II) In the case of a model that has not been so evaluated and supported by data with respect to such a population, the population that would be furnished services under such model if the model were evaluated under the demonstration under subsection (e) would represent a sufficient

number of individuals enrolled under this part to ensure meaningful evaluation.

''(iii) Such model, including if evaluated under the demonstration under subsection (e), would not deny or limit the coverage or provision of benefits under this title for applicable individuals.

''(iv) The implementation of such model as an eligible APM under this section is expected—

''(I) to reduce spending under this title without reducing the quality of care; or

''(II) improve the quality of patient care without increasing spending.

''(v) The proposal for such model demonstrates—

''(I) the potential to successfully manage the cost of furnishing items and services under this title so as to not result in expenditures under this title for individuals participating under such APM being greater than expenditures under this title for such

individuals if the APM were not implemented;

''(II) the ability to maintain or improve the overall patient care; and

''(III) the ability to maintain or improve the quality of care provided to individuals enrolled under this part who participate under such mode.

''(vi) The model provides for a payment arrangement—

''(I) covering at least items and services furnished under this part by eligible professionals participating in the model;

''(II) in the case such payment arrangement does not provide for payment under the fee schedule under section 1848 for such items and services furnished by such eligible professionals, that provides for a payment adjustment based on meaningful EHR use comparable to such adjustment that would otherwise apply under section 1848; and

''(III) that provides for a payment adjustment based on quality measures comparable to such adjustment that would otherwise apply under section 1848.

''(C) CRITERIA FOR RECOMMENDING MODELS FOR APPROVAL WITHOUT EVALUATION UNDER DEMONSTRATION.—The APM contracting entity may make a recommendation under subparagraph (A)(ii), with respect to an Alternative Payment Model, only if the entity determines that the model has already been evaluated for a sufficient enough period and through such evaluation the model was shown—

''(i) to have satisfied the criteria described in each of clauses (i), (ii), (iii), and (vi) of subparagraph (B);

''(ii) to demonstrate each of the abilities described in clause (v) of such subparagraph; and

''(iii)(I) to reduce spending under this title without reducing the quality of care; or

''(II) improve the quality of patient care without increasing spending.

"(D) TRANSPARENCY AND DISCLOSURES.—

"(i) DISCLOSURES.—Not later than 90 days after receipt of a submission of a model under subsection (c) by an entity, the APM contracting entity shall submit to the Secretary and such entity and make publicly available a notification on whether or not, and if so how, the model meets criteria for recommending such model under subparagraph (A), including whether or not such model requires a waiver under paragraph (2). In the case that the APM contracting entity determines not to recommend such model under this paragraph, such notification shall include an explanation of the reasons for not making such a recommendation. Any information made publicly available pursuant to the previous sentence shall not include proprietary data.

"(ii) SUBMISSION OF RECOMMENDED MODELS.—The APM contracting entity shall at least quarterly submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the

Centers for Medicare & Medicaid Services the following:

''(I) The models recommended under subparagraph (A)(i), including any such models that require a waiver under paragraph (2), and the data and analyses on such recommended models that support the criteria described in subparagraph (B).

''(II) The models recommended under subparagraph (A)(ii), including any such models that require a waiver under paragraph (2), and the data and analyses on such recommended models that support the criteria described in subparagraph (C).

For any year beginning with 2015 that the APM contracting does not recommend any models under subparagraph (A), the entity shall instead satisfy this clause by submitting to the Secretary and making publicly available an explanation for not having any such recommendations.

''(2) MODELS REQUIRING WAIVER APPROVAL.—

''(A) IN GENERAL.—In the case that an Alternative Payment Model recommended under paragraph (1)(A)(i) would require a waiver from any requirement under this title, in determining approval of such model, the Secretary may make such a waiver in order for such model to be evaluated under the demonstration program (if described in clause (i) of such paragraph).

''(B) APPROVAL.—Not later than 90 days after the date of the receipt of such submission for a model, the Secretary shall notify the APM contracting entity and the entity submitting such model under subsection (c) whether or not such a waiver for such model is provided and the reason for any denial of such a waiver.

''(e) DEMONSTRATION.—

''(1) IN GENERAL.—Subject to paragraphs (5), (6), and (7), the Secretary may conduct a demonstration program, with respect to an Alternative Payment Model approved under paragraph (2), under which participating entities shall be paid under this title in accordance with the payment arrangement under such model and such model shall be evaluated by the independent evaluation entity

under paragraph (3). The duration of a demonstration program under this subsection, with respect to such a model, shall be 3 years (or a shorter period, taking into account the applicable recommendation under subsection (d)(1)(A)(i)).

''(2) APPROVAL BY SECRETARY OF MODELS FOR DEMONSTRATION.—Not later than 90 days after the date of receipt of a recommendation under subsection (d)(1)(A)(i), with respect to an Alternative Payment Model, the Secretary shall approve such model for a demonstration program under this subsection only if the Secretary determines the model satisfies the criteria described in subsection (d)(1)(B). The Secretary shall periodically make a available a list of such models so approved.

''(3) PARTICIPATING ENTITIES.—To participate under a demonstration program under this subsection, with respect to an Alternative Payment Model, a physician, practitioner, or other supplier shall enter into a contract with the Administrator of the Centers for Medicare & Medicaid Services under this subsection. For purposes of this section, such a physician, practitioner, or supplier who so participates under such an Alternative Payment Model

shall be referred to as a 'participating APM provider'.

''(4) REPORTING AND EVALUATION.—

''(A) INDEPENDENT EVALUATION ENTITY.—Under this subsection, the Secretary shall enter into a contract with an independent entity to evaluate Alternative Payment Models under demonstration programs under this subsection based on appropriate measures specified under subparagraph (B). In this section, such entity shall be referred to as the 'independent evaluation entity'. Such contract shall be entered into in a timely manner so as to ensure evaluation of an Alternative Payment Model under a demonstration program under this subsection may begin as soon as possible after the model is approved under paragraph (2).

''(B) PERFORMANCE MEASURES.—For purposes of this subsection, the Secretary shall specify—

''(i) measures to evaluate Alternative Payment Models under demonstration programs under this subsection, which may include measures suggested under subsection (c) and shall be sufficient to allow

for a comprehensive assessment of such a model; and

''(ii) quality measures on which participating entities shall report, which shall be similar to measures applicable under section 1848(k).

''(C) REPORTING REQUIREMENTS.—A contract entered into with a participating APM provider under paragraph (3) shall require such provider to report on appropriate measures specified under subparagraph (B).

''(D) PERIODIC REVIEW.—The independent evaluation entity shall periodically review and analyze and submit such analysis to the Secretary and the participating entities involved data reported under subparagraph (C) and such other data as deemed necessary to evaluate the model.

''(E) FINAL EVALUATION.—Not later than 6 months after the date of completion of a demonstration program, the independent evaluation entity shall submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services (and make publicly available)

a report on each model evaluated under such program. Such report shall include—

''(i) outcomes on the clinical and claims data received through such program with respect to such model;

''(ii) recommendations on—

''(I) whether or not such model should be implemented as an eligible APM under this section; or

''(II) whether or not the evaluation of such model under the demonstration program should be extended or expanded;

''(iii) the justification for each such recommendation described in clause (ii); and

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

''(5) APPROVAL OF EXTENDING EVALUATION UNDER DEMONSTRATION.—Not later than 90 days after the date of receipt of a submission under paragraph (4)(E), the Secretary shall, including based on a recommendation submitted under such paragraph,

determine whether an Alternative Payment Model may be extended or expanded under the demonstration program.

''(6) TERMINATION.—The Secretary shall terminate a demonstration program for a model under this subsection unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under this title, certifies), after testing has begun, that the model is expected to—

''(A) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under this title;

''(B) reduce spending under this title without reducing the quality of care; or

''(C) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(7) FUNDING.—

''(A) IN GENERAL.—There are appropriated, from amounts in the Federal Supplementary Medical Insurance Trust Fund under

section 1841 not otherwise appropriated, $2,000,000,000 for the purposes described in subparagraph (B), of which no more than 2.5 percent may be used for the purpose described in clause (iii) of such subparagraph. Amounts transferred under this subparagraph shall be available until expended.

''(B) PURPOSES.—Amounts appropriated under subparagraph (A) shall be used for—

''(i) payments for items and services furnished by participating entities under an Alternative Payment Model under a demonstration program under this subsection that—

''(I) would not otherwise be eligible for payment under this title; or

''(II) exceed the amount of payment that would otherwise be made for such items and services under this title if such items and services were not furnished under such demonstration program;

''(ii) the evaluations provided for under this section of models under such a demonstration program;

''(iii) payment to the contracting entity for carrying out its duties under this section; and

''(iv) for otherwise carrying out this subsection.

''(C) LIMITATION.—The amounts appropriated under subparagraph (A) are the only amounts authorized or appropriated to carry out the purposes described in subparagraph (B).

''(f) IMPLEMENTATION OF RECOMMENDED MODELS AS ELIGIBLE APMS.—

''(1) IN GENERAL.—Not later than the applicable date under paragraph (2), the Secretary shall, implement an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I) as an eligible APM only if—

''(A) the Secretary determines that such model is expected to—

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

''(ii) improve the quality of patient care without increasing spending;

''(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that

such model would reduce (or would not result in any increase in) program spending under this title; and

''(C) the Secretary determines that such model would not deny or limit the coverage or provision of benefits under this title for applicable individuals.

Not later than 90 days after the date of issuance of a proposed rule, with respect to an Alternative Payment Model, the Medicare Payment Advisory Commission shall submit comments to Congress and the Secretary evaluating the reports from the contracting entity and independent evaluation entity on such model regarding the model's impact on expenditures and quality of care under this title.

''(2) APPLICABLE DATE.—For purposes of paragraph (1), the applicable date under this paragraph—

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

''(B) for an Alternative Payment Model recommended under subsection (e)(4)(E)(ii)(I)

is 90 days after the date of submission of such recommendation

''(3) JUSTIFICATION FOR DISAPPROVALS.—In the case that an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I) is not implemented as an eligible APM under this subsection, the Secretary shall make publicly available the rational, in detail, for such decision.

''(g) PERIODIC REVIEW AND TERMINATION.—

''(1) PERIODIC REVIEW.—In the case of an Alternative Payment Model that has been implemented, the Secretary and the Chief Actuary of the Centers for Medicare & Medicaid Services shall review such model every 3 years to determine (and certify, in the case of the Chief Actuary and spending under this title), for the previous 3 years, whether the model has—

''(A) reduced the quality of care, or

''(B) increased spending under this title,

compared to the quality of care or spending that would have resulted if the model had not been implemented.

''(2) TERMINATION.—

''(A) QUALITY OF CARE REDUCTION TERMINATION.—If based upon such review the Secretary determines under paragraph (1)(A) that the model has reduced the quality of care, the Secretary may terminate such model.

''(B) SPENDING INCREASE TERMINATION.—Unless such Chief Actuary certifies under paragraph (1)(B) that the expenditures under this title under the model do not exceed the expenditures that would otherwise have been made if the model had not been implemented for the period involved, the Secretary shall terminate such model.

''(h) DISSEMINATION OF ELIGIBLE APMS.—Under this section there shall be established a process for specifying, and making publicly available a list of, all eligible APMs, which shall include at least those implemented under subsection (f) and demonstrations carried out with respect to payments under section 1848 through authority in existence as of the day before the date of the enactment of this section. Under such process such list shall be periodically updated and, beginning with January 1, 2015, and annually thereafter, such list shall be published in the Federal Register.''.

(2) CONFORMING AMENDMENT.—Section 1848(a)(1) of the Social Security Act (42 U.S.C. 1395w–4(a)(1)) is amended by striking ''shall instead'' and inserting ''shall, subject to section 1848A, instead''.

SEC. 3. EXPANDING AVAILABILITY OF MEDICARE DATA.

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

(1) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning with 2014, notwithstanding the second sentence of paragraph (4)(D) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), a qualified entity may use data received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), for additional analyses (as determined appropriate by the Secretary of Health and Human Services) that such entity may provide or sell to providers of services and suppliers (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(2) DEFINITIONS.—In this section:

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

(B) The terms ''supplier'' and ''provider of services'' have the meanings given such terms in subsections (d) and (u), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

(b) ACCESS TO MEDICARE DATA TO PROVIDERS OF SERVICES AND SUPPLIERS TO FACILITATE DEVELOPMENT OF ALTERNATIVE PAYMENT MODELS AND TO QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Consistent with applicable laws and regulations with respect to privacy and other relevant matters, the Secretary shall provide Medicare claims data for non-public use (in a form and manner determined to be appropriate) to—

(1) qualified entities, that may share with providers of services and suppliers that are registered or authorized users or subscribers, in order to facilitate the development of new models of care (including development of Alternate Payment Models under section 1848A of the Social Security Act, models for

small group specialty practices, and care coordination models); and

(2) qualified clinical data registries under section 1848(m)(3)(E)) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)) for purposes of linking such data with clinical outcomes data and performing analysis and research to support quality improvement.

SEC. 4. ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.

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

''(8) ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.—

''(A) IN GENERAL.—In order to promote the coordination of care by an applicable physician (as defined in subparagraph (B)) for individuals with complex chronic care needs who are furnished items and services by multiple physicians and other suppliers and providers of services, the Secretary shall—

''(i) develop one or more HCPCS codes for complex chronic care manage-

ment services for individuals with complex chronic care needs; and

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

''(B) APPLICABLE PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'applicable physician' means a physician (as defined in section 1861(r)(1)) who—

''(i) is certified as a medical home (by achieving an accreditation status of level 3 by the National Committee for Quality Assurance);

''(ii) is recognized as a patient-centered specialty practice by the National Committee for Quality Assurance;

''(iii) has received equivalent certification (as determined by the Secretary); or

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

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

''(D) SINGLE APPLICABLE PHYSICIAN PAYMENT.—In carrying out this paragraph, the Secretary shall only make payment to a single applicable physician for complex chronic care management services furnished to an individual.''.

SEC. 5. MISCELLANEOUS.

(a) SOLICITATIONS, RECOMMENDATIONS, AND REPORTS.—

(1) SOLICITATION FOR RECOMMENDATIONS ON EPISODES OF CARE DEFINITION.—The Administrator of the Centers for Medicare & Medicaid Services shall request eligible professional organizations (as defined in section 1848(k)(3) of the Social Security Act (42 U.S.C. 1395w–4(k)(3))) and other relevant stakeholders to submit recommendations for defining non-acute related episodes of care for purposes of applying such definition under subsections (k) and (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and section 1848A of such

Act, as added by subsections (b) and (c) of section 2.

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

(A) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall solicit from eligible professional organizations (as defined in section 1848(k)(3) of the Social Security Act (42 U.S.C. 1395w–4(k)(3))) recommendations for payment bundles for chronic conditions and expensive, high volume services for which payment is made under title XVIII of such Act.

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

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

(A) BIANNUAL PROGRESS REPORTS.—Not later than January 15, 2016, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress and post on the public Internet website of the Centers for

Medicare & Medicaid Services a biannual progress report—

(i) on the implementation of paragraph (9) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)), as added by section 2(b)(2), and the quality update incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by section 2(b)(3);

(ii) that includes an evaluation of such paragraph and such quality update incentive program and recommendations with respect to such program and appropriate update mechanisms; and

(iii) on the actions taken to promote and fulfill the identification of eligible APMs under section 1848A of the Social Security Act, as added by section 2(c), for application under such section 1848A.

(B) GAO AND MEDPAC REPORTS.—

(i) GAO REPORT ON INITIAL STAGES OF PROGRAM.—The Comptroller General of the United States shall submit to Congress a report analyzing the extent to

which the system under section 1848(k)(9) of the Social Security Act (42 U.S.C. 1395w–4(k)(9)) and such quality update incentive program under section 1848(q) of the Social Security Act, as added by section 2(b), as of such date, is successfully satisfying performance objectives, including with respect to—

(I) the process for developing and selecting measures and activities under subsection (k)(9) of section 1848 of such Act (42 U.S.C. 1395w–4);

(II) the process for assessing performance against such measures and activities under subsection (q) of such section; and

(III) the adequacy of the measures and activities so selected.

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

(I) GAO.—The Comptroller General of the United States shall evaluate the initial phase of the quality up-

date incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and shall submit to Congress, not later than 2019, a report with recommendations for improving such quality update incentive program.

(II) MEDPAC.—In the course of its March Report to Congress on Medicare payment policy, MedPAC shall analyze the initial phase of such quality update incentive program and make recommendations, as appropriate, for improving such quality update incentive program.

(iii) MEDPAC REPORT ON PAYMENT SYSTEM ALTERNATIVES.—

(I) IN GENERAL.—Not later than June 15, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report that analyzes multiple options for alternative payment models in lieu of section 1848 of the Social Security Act (42 U.S.C. 1395w–4). In analyzing such models,

the Medicare Payment Advisory Commission shall examine at least the following models:

(aa) Accountable care organization payment models.

(bb) Primary care medical home payment models.

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

(dd) Gainsharing arrangements

(II) ITEMS TO BE INCLUDED.—Such report shall include information on how each recommended new payment model will achieve maximum flexibility to reward high quality, efficient care.

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

Internet website of the Centers for Medicare & Medicaid Services annual reports on such topics.

(b) RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.—

(1) ELIGIBLE PHYSICIANS REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)) is amended by adding at the end the following new paragraph:

''(8) PHYSICIAN REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—

''(A) IN GENERAL.—The Secretary shall implement a system for the periodic reporting by physicians of data on the accuracy of relative values under this subsection, such as data relating to service volume and time. Such data shall be submitted in a form and manner specified by the Secretary and shall, as appropriate, incorporate data from existing sources of data, patient scheduling systems, cost accounting systems, and other similar systems.

''(B) IDENTIFICATION OF REPORTING COHORT.—Not later than January 1, 2015, the Secretary shall establish a mechanism for physi-

cians to participate under the reporting system under this paragraph, all of whom shall collectively be referred to under this paragraph as the 'reporting group'. The reporting group shall include physicians across settings that collectively represent a range of specialties and practitioner types, furnish a range of physicians' services, and serve a range of patient populations.

"(C) INCENTIVE TO REPORT.—Under the system under this paragraph, the Secretary may provide for such payments under this part to physicians included in the reporting group as the Secretary determines appropriate to compensate such physicians for reporting data under the system. Such payments shall be provided in such form and manner as specified by the Secretary. In carrying out this subparagraph, reporting by such a physician under this paragraph shall not be treated as the furnishing of physicians' services for purposes of applying this section.

"(D) FUNDING.—To carry out this paragraph (other than with respect to payments made under subparagraph (C)), in addition to

funds otherwise appropriated, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of $1,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.''.

(2) RELATIVE VALUE ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

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

''(M) ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—With respect to fee schedules established for 2016, 2017, and 2018, the Secretary shall—

''(i) identify, based on the data reported under paragraph (8) and other relevant data, misvalued services for which adjustments to the relative values established under this paragraph would result in a net reduction in expenditures under the

fee schedule under this section, with respect to such year, of not more than 1 percent of the projected amount of expenditures under such fee schedule for such year; and

''(ii) make such adjustments for each such year so as to result in such a net reduction for such year.''.

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

''(VIII) REDUCTIONS FOR MISVALUED PHYSICIANS' SERVICES.—Reduced expenditures attributable to subparagraph (M).''.

(c) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDER STANDARDS OF CARE.—

(1) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

(2) DEFINITIONS.—For purposes of this subsection:

(A) The term ''Federal health care provision'' means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I and subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and titles XVIII and XIX of the Social Security Act.

(B) The term ''health care provider'' means any individual or entity—

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

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) The term ''medical malpractice or medical liability action or claim'' means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as

such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) The term ''State'' includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) NO PREEMPTION.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.