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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.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Patient Access and Quality Improvement Act
6 of 2013”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Reform of sustainable growth rate (SGR) and Medicare payment for
physicians' services.

Sec. 3. Expanding availability of Medicare data.

Sec. 4. Encouraging care coordination and medical homes.

Sec. 5. Miscellaneous.

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

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

7 (1) REPEAL OF SGR PAYMENT METHOD-
8 OLOGY.—Section 1848 of the Social Security Act
9 (42 U.S.C. 1395w–4) is amended—

10 (A) in subsection (d)—

11 (i) in paragraph (1)(A), by inserting
12 “or a subsequent paragraph or section
13 1848A” after “paragraph (4)”; and

14 (ii) in paragraph (4)—

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

18 (II) in subparagraph (A), by
19 striking “a year beginning with 2001”
20 and inserting “2001, 2002, and
21 2003”; and

22 (B) in subsection (f)—

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

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

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

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

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

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

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

22 “(16) UPDATE BEGINNING WITH 2019.—

23 “(A) IN GENERAL.—Subject to subpara-
24 graph (B), the update to the single conversion

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

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

11 (B) in subsection (i)(1)—

12 (i) by striking “and” at the end of
13 subparagraph (D);

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

17 (iii) by adding at the end the fol-
18 lowing new subparagraph:

19 “(F) the implementation of subsection
20 (q).”.

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

1 (A) in subsection (k)(1), in the first sen-
2 tence, by inserting “and, if applicable, clinical
3 practice improvement activities,” after “quality
4 measures”;

5 (B) in subsection (k)(2)—

6 (i) in subparagraph (C)—

7 (I) in the subparagraph heading,
8 by striking “AND SUBSEQUENT
9 YEARS” and inserting “THROUGH
10 2018”; and

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

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

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

18 “(D) FOR 2019 AND SUBSEQUENT
19 YEARS.—For purposes of reporting data on
20 quality measures and, as applicable clinical
21 practice improvement activities, for covered pro-
22 fessional services furnished during the perform-
23 ance period (as defined in subsection (q)(2)(B))
24 with respect to 2019 and the performance pe-
25 riod with respect to each subsequent year, sub-

1 ject to subsection (q)(1)(D), the quality meas-
2 ures and clinical practice improvement activities
3 specified under this paragraph shall be, with re-
4 spect to an eligible professional, the quality
5 measures and, as applicable, clinical practice
6 improvement activities within the final core
7 measure set under paragraph (9)(F) applicable
8 to the peer cohort of such provider and year in-
9 volved.”; and

10 (iv) in subparagraph (E), as redesign-
11 nated by subparagraph (B)(ii) of this para-
12 graph, by striking “AND SUBSEQUENT
13 YEARS”;

14 (C) in subsection (k)(3)—

15 (i) in the paragraph heading, by strik-
16 ing “COVERED PROFESSIONAL SERVICES
17 AND ELIGIBLE PROFESSIONALS DEFINED”
18 and inserting “DEFINITIONS”; and

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

21 “(C) CLINICAL PRACTICE IMPROVEMENT
22 ACTIVITIES.—The term ‘clinical practice im-
23 provement activity’ means an activity that rel-
24 evant eligible professional organizations and
25 other relevant stakeholders identify as improv-

1 ing clinical practice or care delivery and that
2 the Secretary determines, when effectively exe-
3 cuted, is likely to result in improved outcomes.

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

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

15 (D) in subsection (k)(7), by striking “ and
16 the application of paragraphs (4) and (5)” and
17 inserting “, the application of paragraphs (4)
18 and (5), and the implementation of paragraph
19 (9)”;

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

22 “(9) ESTABLISHMENT OF FINAL CORE MEAS-
23 URE SETS.—

24 “(A) IN GENERAL.—Under the system
25 under this subsection—

1 “(i) for each peer cohort identified
2 under subparagraph (B) and in accordance
3 with this paragraph, there shall be pub-
4 lished a final core measure set under sub-
5 paragraph (F), which shall consist of qual-
6 ity measures and may also consist of clin-
7 ical practice improvement activities, with
8 respect to which eligible professionals shall,
9 subject to subsection (m)(3)(C), be as-
10 sessed for purposes of determining, for
11 years beginning with 2019, the quality ad-
12 justment under subsection (q)(3) applica-
13 ble to such professionals; and

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

18 “(B) PEER COHORTS.—The Secretary
19 shall identify (and publish a list of) peer co-
20 horts by which eligible professionals shall self-
21 identify for purposes of this subsection and sub-
22 section (q) with respect to a performance period
23 (as defined in subsection (q)(2)(B)) for a year
24 beginning with 2019. For purposes of this sub-
25 section and subsection (q), the Secretary shall

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

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

16 “(ii) shall be updated from time to
17 time.

18 “(C) QUALITY MEASURES FOR CORE MEAS-
19 URE SETS.—

20 “(i) DEVELOPMENT.—Under the sys-
21 tem under this subsection there shall be es-
22 tablished a process for the development of
23 quality measures under this subparagraph
24 for purposes of potential inclusion of such

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

3 “(I) there shall be coordination,
4 to the extent possible, across organi-
5 zations developing such measures;

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

14 “(III) there is encouraged to be
15 developed, as appropriate, meaningful
16 outcome measures (or quality of life
17 measures in cases for which outcomes
18 may not be a valid measurement),
19 functional status measures, and pa-
20 tient experience measures; and

21 “(IV) measures developed under
22 this clause shall be developed, to the
23 extent possible, in accordance with
24 best practices and clinical practice
25 guidelines.

1 “(ii) QUALITY DOMAINS.—For pur-
2 poses of this paragraph, the term ‘quality
3 domains’ means at least the following do-
4 mains:

5 “(I) Clinical care.

6 “(II) Safety.

7 “(III) Care coordination.

8 “(IV) Patient and caregiver expe-
9 rience.

10 “(V) Population health and pre-
11 vention.

12 “(D) PROCESS FOR ESTABLISHING CORE
13 MEASURE SETS.—

14 “(i) IN GENERAL.—Under the system
15 under this subsection, for purposes of sub-
16 paragraph (A), there shall be established a
17 process to approve final core measure sets
18 under this paragraph for peer cohorts.
19 Each such final core measure set shall be
20 composed of quality measures (and, as ap-
21 plicable, clinical practice improvement ac-
22 tivities) with respect to which eligible pro-
23 fessionals within such peer cohort shall re-
24 port under this subsection and be assessed

1 under subsection (q). Such process shall
2 provide—

3 “(I) for the establishment of cri-
4 teria, which shall be made publicly
5 available before the request is made
6 under clause (ii), for selecting such
7 measures and activities for potential
8 inclusion in such a final core measure
9 set; and

10 “(II) that all peer cohorts, and to
11 the extent practicable all quality do-
12 mains, are addressed by measures
13 and, as applicable, clinical practice
14 improvement activities selected to be
15 included in a core measure set under
16 this paragraph, which may include
17 through the use of such a measure or
18 clinical practice improvement activity
19 that addresses more than one such
20 domain or cohort.

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

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

12 “(E) CORE MEASURE SETS.—

13 “(i) IN GENERAL.—Under the process
14 established under subparagraph (D)(i), the
15 Secretary—

16 “(I) shall select, from quality
17 measures described in clause (ii) ap-
18 plicable to a peer cohort, quality
19 measures to be included in a core
20 measure set for such cohort;

21 “(II) shall, to the extent there
22 are insufficient quality measures ap-
23 plicable to a peer cohort to address
24 one or more applicable quality do-
25 mains, select to be included in a core

1 measure set for such cohort such clin-
2 ical practice improvement activities
3 described in clause (ii)(IV) as are
4 needed and available to sufficiently
5 address such an applicable domain
6 with respect to such peer cohort; and

7 “(III) may select, to the extent
8 determined appropriate, any addi-
9 tional clinical practice improvement
10 activities described in clause (ii)(IV)
11 applicable to a peer cohort to be in-
12 cluded in a core measure set for such
13 cohort.

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

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

1 “(I) a measure endorsed by a
2 consensus-based entity;

3 “(II) a measure developed under
4 paragraph (2)(C) or a measure other-
5 wise applied or developed for a similar
6 purpose under this section;

7 “(III) a measure developed under
8 subparagraph (C); or

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

11 A measure or activity may be selected
12 under this subparagraph, regardless of
13 whether such measure or activity was pre-
14 viously published in a proposed rule. A
15 measure so selected shall be evidence-based
16 but (other than a measure described in
17 subclause (I)) shall not be required to be
18 consensus-based.

19 “(iii) TRANSPARENCY.—Before pub-
20 lishing in a final regulation a core measure
21 set under clause (i) as a final core measure
22 set under subparagraph (F), the Secretary
23 shall—

24 “(I) submit for publication in ap-
25 plicable specialty-appropriate peer-re-

1 viewed journals such core measure set
2 under clause (i) and the method for
3 developing and selecting measures
4 within such set, including clinical and
5 other data supporting such measures,
6 and, as applicable, the method for se-
7 lecting clinical practice improvement
8 activities included within such set;
9 and

10 “(II) regardless of whether or not
11 the core measure set or method is
12 published in such a journal under sub-
13 clause (I), provide for notice of the
14 proposed regulation in the Federal
15 Register, including with respect to the
16 applicable methods and data described
17 in subclause (I), and a period for pub-
18 lic comment thereon.

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

1 in subparagraph (E)(iii)(I)) for each peer co-
2 hort to be applied for such performance period.

3 “(G) PERIODIC REVIEW AND UPDATES.—

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

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

19 “(II) the final core measure sets
20 published under subparagraph (F) for
21 each year such sets are to be applied
22 to peer cohorts of eligible profes-
23 sionals to ensure that each applicable
24 set continues to meet the conditions

1 applicable to such sets before being so
2 published.

3 “(ii) COLLABORATION WITH STAKE-
4 HOLDERS.—In carrying out clause (i), rel-
5 evant eligible professional organizations
6 and other relevant stakeholders may iden-
7 tify and submit updates to quality meas-
8 ures and clinical practice improvement ac-
9 tivities selected under this paragraph for
10 inclusion in final core measure sets as well
11 as any additional quality measures and
12 clinical practice improvement activities.
13 Not later than November 15 of the year
14 prior to the first day of a performance pe-
15 riod, submissions under this clause shall be
16 reviewed.

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

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

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

7 “(II) removed, from final core
8 measure sets, quality measures and
9 clinical practice improvement activities
10 that are no longer meaningful; and

11 “(III) updated final core measure
12 sets published under subparagraph
13 (F) in the same manner as such sets
14 are approved under such subpara-
15 graph.

16 For purposes of this subsection and sub-
17 section (q), a final core measure set, as up-
18 dated under this subparagraph, shall be
19 treated in the same manner as a final core
20 measure set published under subparagraph
21 (F).

22 “(iv) TRANSPARENCY.—

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

1 (III) of clause (iii) that adds, materi-
2 ally changes, or removes a measure or
3 activity from a measure set, such up-
4 date shall not apply under this sub-
5 section or subsection (q) unless notifi-
6 cation of such update is made avail-
7 able to applicable eligible profes-
8 sionals.

9 “(II) PUBLIC AVAILABILITY OF
10 UPDATED FINAL CORE MEASURE
11 SETS.—Subparagraph (E)(iii) shall
12 apply with respect to measure sets up-
13 dated under subclause (II) or (III) of
14 clause (iii) in the same manner as
15 such subparagraph applies to applica-
16 ble core measure sets under subpara-
17 graph (E).

18 “(H) COORDINATION WITH EXISTING PRO-
19 GRAMS.—The development and selection of
20 quality measures and clinical practice improve-
21 ment activities under this paragraph shall, as
22 appropriate, be coordinated with the develop-
23 ment and selection of existing measures and re-
24 quirements, such as the development of the
25 Physician Compare Website under subsection

1 (m)(5)(G) and the application of resource use
2 management under subsection (n). To the ex-
3 tent feasible, such measures and activities shall
4 align with measures used by other payers and
5 with measures and activities in use under other
6 programs in order to streamline the process of
7 such development and selection under this para-
8 graph. The Secretary shall develop a plan to in-
9 tegrate reporting on quality measures under
10 this subsection with reporting requirements
11 under subsection (o) relating to the meaningful
12 use of certified EHR technology.

13 “(I) CONSULTATION WITH RELEVANT ELI-
14 GIBLE PROFESSIONAL ORGANIZATIONS AND
15 OTHER RELEVANT STAKEHOLDERS.—Relevant
16 eligible professional organizations (as defined in
17 paragraph (3)(D)) and other relevant stake-
18 holders, including State and national medical
19 societies, shall be consulted in carrying out this
20 paragraph.

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

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

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

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

16 “(q) QUALITY UPDATE INCENTIVE PROGRAM.—

17 “(1) ESTABLISHMENT.—

18 “(A) IN GENERAL.—The Secretary shall
19 establish an eligible professional quality update
20 incentive program (in this section referred to as
21 the ‘quality update incentive program’) under
22 which—

23 “(i) there is developed and applied, in
24 accordance with paragraph (2), appro-
25 priate methodologies for assessing the per-

1 performance of eligible professionals with re-
2 spect to quality measures and clinical prac-
3 tice improvement activities included within
4 the final core measure sets published under
5 subsection (k)(9)(F) applicable to the peer
6 cohorts of such providers;

7 “(ii) there is applied, consistent with
8 the system under subsection (k), methods
9 for collecting information needed for such
10 assessments (which shall involve the min-
11 imum amount of administrative burden re-
12 quired to ensure reliable results); and

13 “(iii) the applicable update adjust-
14 ments under paragraph (3) are determined
15 by such assessments.

16 “(B) DEFINITIONS.—

17 “(i) ELIGIBLE PROFESSIONAL.—In
18 this subsection, the term ‘eligible profes-
19 sional’ has the meaning given such term in
20 subsection (k)(3), except that such term
21 shall not include a professional who has a
22 payment arrangement described in section
23 1848A(a)(1) in effect.

24 “(ii) PEER COHORTS; CLINICAL PRAC-
25 TICE IMPROVEMENT ACTIVITIES; ELIGIBLE

1 PROFESSIONAL ORGANIZATIONS.—In this
2 subsection, the terms ‘peer cohort’, ‘clinical
3 practice improvement activity’, and ‘eligible
4 professional organization’ have the mean-
5 ings given such terms in subsection (k)(3).

6 “(C) CONSULTATION WITH ELIGIBLE PRO-
7 FESSIONAL ORGANIZATIONS AND OTHER REL-
8 EVANT STAKEHOLDERS.—Eligible professional
9 organizations and other relevant stakeholders,
10 including State and national medical societies,
11 shall be consulted in carrying out this sub-
12 section.

13 “(D) APPLICATION AT GROUP PRACTICE
14 LEVEL.—The Secretary shall establish a proc-
15 ess, consistent with subsection (m)(3)(C), under
16 which the provisions of this subsection are ap-
17 plied to eligible professionals in a group prac-
18 tice if the group practice reports measures de-
19 termined appropriate by the Secretary under
20 such subsection.

21 “(E) COORDINATION WITH EXISTING PRO-
22 GRAMS.—The application of measures and clin-
23 ical practice improvement activities and assess-
24 ment of performance under this subsection
25 shall, as appropriate, be coordinated with the

1 application of measures and assessment of per-
2 formance under other provisions of this section.

3 “(2) ASSESSING PERFORMANCE WITH RESPECT
4 TO FINAL CORE MEASURE SETS FOR APPLICABLE
5 PEER COHORTS.—

6 “(A) ESTABLISHMENT OF METHODS FOR
7 ASSESSMENT.—

8 “(i) IN GENERAL.—Under the quality
9 update incentive program, the Secretary
10 shall—

11 “(I) establish one or more meth-
12 ods, applicable with respect to a per-
13 formance period, to assess (using a
14 scoring scale of 0 to 100) the per-
15 formance of an eligible professional
16 with respect to, subject to paragraph
17 (1)(D), quality measures and clinical
18 practice improvement activities in-
19 cluded within the final core measure
20 set published under subsection
21 (k)(9)(F) applicable for the period to
22 the peer cohort in which the provider
23 self-identified under subsection
24 (k)(9)(B) for such period; and

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

7 “(ii) METHODS.—Such methods shall,
8 with respect to an eligible professional,
9 provide that the performance of such pro-
10 fessional shall, subject to paragraph
11 (1)(D), be assessed for a performance pe-
12 riod with respect to the quality measures
13 and clinical practice improvement activities
14 within the final core measure set for such
15 period for the peer cohort of such profes-
16 sional and on which information is col-
17 lected from such professional.

18 “(iii) WEIGHTING OF MEASURES.—
19 Such a method may provide for the assign-
20 ment of different scoring weights or, as ap-
21 propriate, other factors—

22 “(I) for quality measures and
23 clinical practice improvement activi-
24 ties;

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

3 “(III) based on the extent to
4 which a quality measure or clinical
5 practice improvement activity mean-
6 ingfully assesses quality.

7 “(iv) RISK ADJUSTMENT.—Such a
8 method shall provide for appropriate risk
9 adjustments.

10 “(v) INCORPORATION OF OTHER
11 METHODS OF MEASURING PHYSICIAN
12 QUALITY.—In establishing such methods,
13 there shall be, as appropriate, incorporated
14 comparable methods of measurement from
15 physician quality incentive programs under
16 this subsection.

17 “(B) PERFORMANCE PERIOD.—There shall
18 be established a period (in this subsection re-
19 ferred to as a ‘performance period’), with re-
20 spect to a year (beginning with 2019) for which
21 the quality adjustment is applied under para-
22 graph (3), to assess performance on quality
23 measures and clinical practice improvement ac-
24 tivities. Each such performance period shall be
25 a period of 12 consecutive months and shall end

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

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

5 “(A) QUALITY ADJUSTMENT.—For pur-
6 poses of subsection (d)(16), if the composite
7 score computed under paragraph (2)(A) for an
8 eligible professional for a year (beginning with
9 2019) is—

10 “(i) a score of 67 or higher, the qual-
11 ity adjustment under this paragraph for
12 the eligible professional and year is 1 per-
13 centage point;

14 “(ii) a score of at least 34, but below
15 67, the quality adjustment under this
16 paragraph for the eligible professional and
17 year is zero; or

18 “(iii) a score below 34, the quality ad-
19 justment under this paragraph for the eli-
20 gible professional and year is -1 percentage
21 point.

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

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

3 “(4) TRANSITION FOR NEW ELIGIBLE PROFES-
4 SIONALS.—In the case of a physician, practitioner,
5 or other supplier that during a performance period,
6 with respect to a year for which a quality adjust-
7 ment is applied under paragraph (3), first becomes
8 an eligible professional (and had not previously sub-
9 mitted claims under this title as a person, as an en-
10 tity, or as part of a physician group or under a dif-
11 ferent billing number or tax identifier), the quality
12 adjustment under this subsection applicable to such
13 physician, practitioner, or supplier—

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

16 “(B) for a year, with respect to a subse-
17 quent performance period, shall be the quality
18 adjustment that would otherwise be applied
19 under this subsection.

20 “(5) FEEDBACK.—

21 “(A) FEEDBACK.—

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

1 but at least quarterly, to each eligible pro-
2 fessional feedback—

3 “(I) on the performance of such
4 provider with respect to quality meas-
5 ures and clinical practice improvement
6 activities within the final core meas-
7 ure set published under subsection
8 (k)(9)(F) for the applicable perform-
9 ance period and the peer cohort of
10 such professional; and

11 “(II) to assess the progress of
12 such professional under the quality
13 update incentive program with respect
14 to a performance period for a year.

15 “(ii) USE OF REGISTRIES AND OTHER
16 MECHANISMS.—Feedback under this sub-
17 paragraph shall, to the extent an eligible
18 professional chooses to participate in a
19 data registry for purposes of this sub-
20 section (including registries under sub-
21 sections (k) and (m)), be provided and
22 based on performance received through the
23 use of such registry, and to the extent that
24 an eligible professional chooses not to par-
25 ticipate in such a registry for such pur-

1 poses, be provided through other similar
2 mechanisms that allow for the provision of
3 such feedback and receipt of such perform-
4 ance information.

5 “(B) DATA MECHANISM.—Under the qual-
6 ity update incentive program, there shall be de-
7 veloped an electronic interactive eligible profes-
8 sional mechanism through which such a profes-
9 sional may receive performance data, including
10 data with respect to performance on the meas-
11 ures and activities developed and selected under
12 this section. Such mechanism shall be developed
13 in consultation with private payers and health
14 insurance issuers (as defined in section
15 2791(b)(2) of the Public Health Service Act) as
16 appropriate.

17 “(C) TRANSFER OF FUNDS.—The Sec-
18 retary shall provide for the transfer of
19 \$100,000,000 from the Federal Supplementary
20 Medical Insurance Trust Fund established in
21 section 1841 to the Center for Medicare & Med-
22 icaid Services Program Management Account to
23 support such efforts to develop the infrastruc-
24 ture as necessary to carry out subsection (k)(9)
25 and this subsection and for purposes of section

1 1889(h). Such funds shall be so transferred on
2 the date of the enactment of this subsection
3 and shall remain available until expended.”.

4 (B) INCENTIVE TO REPORT UNDER QUALITY
5 UPDATE INCENTIVE PROGRAM.—Section
6 1848(a)(8)(A) of the Social Security Act (42
7 U.S.C. 1395w-4(a)(8)(A)) is amended—

8 (i) in clause (i), by striking “With re-
9 spect to” and inserting “Subject to clause
10 (iii), with respect to”; and

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

13 “(iii) APPLICATION TO ELIGIBLE PRO-
14 FESSIONALS NOT REPORTING.—With re-
15 spect to covered professional services (as
16 defined in subsection (k)(3)) furnished by
17 an eligible professional during 2019 or any
18 subsequent year, if the eligible professional
19 does not submit data for the performance
20 period (as defined in subsection (q)(2)(B))
21 with respect to such year on, subject to
22 subsection (q)(1)(D), the quality measures
23 and, as applicable, clinical practice im-
24 provement activities within the final core
25 measure set under subsection (k)(9)(F) ap-

1 applicable to the peer cohort of such pro-
2 vider, the fee schedule amount for such
3 services furnished by such professional
4 during the year (including the fee schedule
5 amount for purposes of determining a pay-
6 ment based on such amount) shall be equal
7 to 95 percent (in lieu of the applicable per-
8 cent) of the fee schedule amount that
9 would otherwise apply to such services
10 under this subsection (determined after ap-
11 plication of paragraphs (3), (5), and (7),
12 but without regard to this paragraph). The
13 Secretary shall develop a minimum per
14 year caseload threshold, with respect to eli-
15 gible professionals, and the previous sen-
16 tence shall not apply to eligible profes-
17 sionals with a caseload for a year below
18 such threshold for such year.”.

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

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

1 tion 1848(k)(3)) about the quality update incentive pro-
2 gram under section 1848(q) and quality measures under
3 section 1848(k)(9) through multiple approaches, including
4 a national dissemination strategy and outreach by medi-
5 care contractors.”.

6 (4) CONFORMING AMENDMENTS.—

7 (A) TREATMENT OF SATISFACTORILY RE-
8 PORTING PQRS MEASURES THROUGH PARTICI-
9 PATION IN A QUALIFIED CLINICAL DATA REG-
10 ISTRY.—Section 1848(m)(3)(D) of the Social
11 Security Act (42 U.S.C. 1395w-4(m)(3)(D)) is
12 amended by striking “For 2014 and subsequent
13 years” and inserting “For each of 2014
14 through 2018”.

15 (B) COORDINATING ENHANCED PQRS RE-
16 PORTING WITH EHR.—Section
17 1848(o)(2)(B)(iii) of the Social Security Act
18 (42 U.S.C. 1395w-4(o)(2)(B)(iii)) is amended
19 by striking “subsection (k)(2)(C)” and inserting
20 “subparagraph (C) or (D) of subsection
21 (k)(2)”.

22 (C) COORDINATING PQRS REPORTING PE-
23 RIOD WITH QUALITY UPDATE INCENTIVE PRO-
24 GRAM PERFORMANCE PERIOD.—Section

1 1848(m)(6)(C) of the Social Security Act (42
2 U.S.C. 1395w-4(m)(6)(C)) is amended—

3 (i) in clause (i), by striking “and (iii)”
4 and inserting “, (iii), and (iv)”; and

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

7 “(iv) COORDINATION WITH QUALITY
8 UPDATE INCENTIVE PROGRAM.—For 2019
9 and each subsequent year the reporting pe-
10 riod shall be coordinated with the perform-
11 ance period under subsection (q)(2)(B).”.

12 (D) COORDINATING EHR REPORTING WITH
13 QUALITY UPDATE INCENTIVE PROGRAM PER-
14 FORMANCE PERIOD.—Section 1848(o)(5)(B) of
15 the Social Security Act (42 U.S.C. 1395w-
16 4(o)(5)(B)) is amended by adding at the end
17 the following: “Beginning for 2019, the EHR
18 reporting period shall be coordinated with the
19 performance period under subsection
20 (q)(2)(B).”.

21 (e) ADVANCING ALTERNATIVE PAYMENT MODELS.—

22 (1) IN GENERAL.—Part B of title XVIII of the
23 Social Security Act (42 U.S.C. 1395w-4 et seq.) is
24 amended by adding at the end the following new sec-
25 tion:

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

2 “(a) PAYMENT MODEL CHOICE PROGRAM.—Pay-
3 ment for covered professional services (as defined in sec-
4 tion 1848(k)) that are furnished by an eligible professional
5 (as defined in such section) under an Alternative Payment
6 Model specified on the list under subsection (h) (in this
7 section referred to as an ‘eligible APM’) shall be made
8 under this title in accordance with the payment arrange-
9 ment under such model. In applying the previous sentence,
10 such a professional with such a payment arrangement in
11 effect, shall be deemed for purposes of section 1848(a)(8)
12 to be satisfactorily submitting data on quality measures
13 for such covered professional services.

14 “(b) PROCESS FOR IMPLEMENTING ELIGIBLE
15 APMS.—

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

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

21 “(B) proposals for potential Alternative
22 Payment Models are submitted in accordance
23 with subsection (c);

24 “(C) Alternative Payment Models so pro-
25 posed are recommended, in accordance with
26 subsection (d), for evaluation, including through

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

3 “(D) applicable Alternative Payment Mod-
4 els are evaluated under such demonstration pro-
5 gram;

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

8 “(F) a comprehensive list of all eligible
9 APMs is made publicly available, in accordance
10 with subsection (h), for application under sub-
11 section (a).

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

14 “(A) IN GENERAL.—For purposes of para-
15 graph (1)(A), the Secretary shall identify and
16 have in effect a contract with an independent
17 entity that has appropriate expertise to carry
18 out the functions applicable to such entity
19 under this section. Such entity shall be referred
20 to in this section as the ‘APM contracting enti-
21 ty’.

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

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

3 “(C) COMPETITIVE PROCEDURES.—Com-
4 petitive procedures (as defined in section 4(5)
5 of the Office of Federal Procurement Policy Act
6 (41 U.S.C. 403(5)) shall be used to enter into
7 a contract under subparagraph (A).

8 “(c) SUBMISSION OF PROPOSED ALTERNATIVE PAY-
9 MENT MODELS.—Beginning not later than 90 days after
10 the date the Secretary enters into a contract under sub-
11 section (b)(2) with the APM contracting entity, physi-
12 cians, eligible professional organizations, health care pro-
13 vider organizations, and other entities may submit to the
14 APM contracting entity proposals for Alternative Payment
15 Models for application under this section. Such a proposal
16 of a model shall include suggestions for measures to be
17 used under subsection (e)(1)(B) for purposes of evaluating
18 such model. In reviewing submissions under this sub-
19 section for purposes of making recommendations under
20 subsection (d)(1), the contracting entity shall focus on
21 submissions for such models that are intended to improve
22 care coordination and quality for patients through modi-
23 fying the manner in which physicians and other providers
24 are paid under this title.

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

3 “(1) RECOMMENDATION.—

4 “(A) IN GENERAL.—Under the process
5 under subsection (b), the APM contracting enti-
6 ty shall at least annually recommend to the
7 Secretary—

8 “(i) based on the criteria described in
9 subparagraph (B), Alternative Payment
10 Models submitted under subsection (c) to
11 be evaluated through a demonstration pro-
12 gram under subsection (e); and

13 “(ii) based on the criteria described in
14 subparagraph (C), Alternative Payment
15 Models submitted under subsection (c) for
16 purposes of implementation under sub-
17 section (f), without evaluation through
18 such a demonstration program.

19 Such a recommendation may be made with re-
20 spect to a model for which a waiver would be
21 required under paragraph (2).

22 “(B) CRITERIA FOR RECOMMENDING MOD-
23 ELS FOR DEMONSTRATION.—The APM con-
24 tracting entity shall make a recommendation
25 under subparagraph (A)(i), with respect to an

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

4 “(i) The model has been supported by
5 meaningful clinical and non-clinical data,
6 with respect to a sufficient population sam-
7 ple, that indicates the model would be suc-
8 cessful at addressing each of the abilities
9 described in clause (v).

10 “(ii) (I) In the case of a model that
11 has already been evaluated and supported
12 by data with respect to a population of in-
13 dividuals enrolled under this part, if the
14 model were evaluated under the dem-
15 onstration under subsection (e) such a
16 population would represent a sufficient
17 number of individuals enrolled under this
18 part to ensure meaningful evaluation.

19 “(II) In the case of a model that has
20 not been so evaluated and supported by
21 data with respect to such a population, the
22 population that would be furnished services
23 under such model if the model were evalu-
24 ated under the demonstration under sub-
25 section (e) would represent a sufficient

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

3 “(iii) Such model, including if evalu-
4 ated under the demonstration under sub-
5 section (e), would not deny or limit the
6 coverage or provision of benefits under this
7 title for applicable individuals.

8 “(iv) The implementation of such
9 model as an eligible APM under this sec-
10 tion is expected—

11 “(I) to reduce spending under
12 this title without reducing the quality
13 of care; or

14 “(II) improve the quality of pa-
15 tient care without increasing spend-
16 ing.

17 “(v) The proposal for such model
18 demonstrates—

19 “(I) the potential to successfully
20 manage the cost of furnishing items
21 and services under this title so as to
22 not result in expenditures under this
23 title for individuals participating
24 under such APM being greater than
25 expenditures under this title for such

1 individuals if the APM were not im-
2 plemented;

3 “(II) the ability to maintain or
4 improve the overall patient care; and

5 “(III) the ability to maintain or
6 improve the quality of care provided
7 to individuals enrolled under this part
8 who participate under such mode.

9 “(vi) The model provides for a pay-
10 ment arrangement—

11 “(I) covering at least items and
12 services furnished under this part by
13 eligible professionals participating in
14 the model;

15 “(II) in the case such payment
16 arrangement does not provide for pay-
17 ment under the fee schedule under
18 section 1848 for such items and serv-
19 ices furnished by such eligible profes-
20 sionals, that provides for a payment
21 adjustment based on meaningful EHR
22 use comparable to such adjustment
23 that would otherwise apply under sec-
24 tion 1848; and

1 “(III) that provides for a pay-
2 ment adjustment based on quality
3 measures comparable to such adjust-
4 ment that would otherwise apply
5 under section 1848.

6 “(C) CRITERIA FOR RECOMMENDING MOD-
7 ELS FOR APPROVAL WITHOUT EVALUATION
8 UNDER DEMONSTRATION.—The APM con-
9 tracting entity may make a recommendation
10 under subparagraph (A)(ii), with respect to an
11 Alternative Payment Model, only if the entity
12 determines that the model has already been
13 evaluated for a sufficient enough period and
14 through such evaluation the model was shown—

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

18 “(ii) to demonstrate each of the abili-
19 ties described in clause (v) of such sub-
20 paragraph; and

21 “(iii)(I) to reduce spending under this
22 title without reducing the quality of care;
23 or

24 “(II) improve the quality of patient
25 care without increasing spending.

1 “(D) TRANSPARENCY AND DISCLO-
2 SURES.—

3 “(i) DISCLOSURES.—Not later than
4 90 days after receipt of a submission of a
5 model under subsection (c) by an entity,
6 the APM contracting entity shall submit to
7 the Secretary and such entity and make
8 publicly available a notification on whether
9 or not, and if so how, the model meets cri-
10 teria for recommending such model under
11 subparagraph (A), including whether or
12 not such model requires a waiver under
13 paragraph (2). In the case that the APM
14 contracting entity determines not to rec-
15 ommend such model under this paragraph,
16 such notification shall include an expla-
17 nation of the reasons for not making such
18 a recommendation. Any information made
19 publicly available pursuant to the previous
20 sentence shall not include proprietary data.

21 “(ii) SUBMISSION OF RECOMMENDED
22 MODELS.—The APM contracting entity
23 shall at least quarterly submit to the Sec-
24 retary, the Medicare Payment Advisory
25 Commission, and the Chief Actuary of the

1 Centers for Medicare & Medicaid Services
2 the following:

3 “(I) The models recommended
4 under subparagraph (A)(i), including
5 any such models that require a waiver
6 under paragraph (2), and the data
7 and analyses on such recommended
8 models that support the criteria de-
9 scribed in subparagraph (B).

10 “(II) The models recommended
11 under subparagraph (A)(ii), including
12 any such models that require a waiver
13 under paragraph (2), and the data
14 and analyses on such recommended
15 models that support the criteria de-
16 scribed in subparagraph (C).

17 For any year beginning with 2015 that the
18 APM contracting does not recommend any
19 models under subparagraph (A), the entity
20 shall instead satisfy this clause by submit-
21 ting to the Secretary and making publicly
22 available an explanation for not having any
23 such recommendations.

24 “(2) MODELS REQUIRING WAIVER APPROVAL.—

1 “(A) IN GENERAL.—In the case that an
2 Alternative Payment Model recommended under
3 paragraph (1)(A)(i) would require a waiver
4 from any requirement under this title, in deter-
5 mining approval of such model, the Secretary
6 may make such a waiver in order for such
7 model to be evaluated under the demonstration
8 program (if described in clause (i) of such para-
9 graph).

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

17 “(e) DEMONSTRATION.—

18 “(1) IN GENERAL.—Subject to paragraphs (5),
19 (6), and (7), the Secretary may conduct a dem-
20 onstration program, with respect to an Alternative
21 Payment Model approved under paragraph (2),
22 under which participating entities shall be paid
23 under this title in accordance with the payment ar-
24 rangement under such model and such model shall
25 be evaluated by the independent evaluation entity

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

6 “(2) APPROVAL BY SECRETARY OF MODELS
7 FOR DEMONSTRATION.—Not later than 90 days
8 after the date of receipt of a recommendation under
9 subsection (d)(1)(A)(i), with respect to an Alter-
10 native Payment Model, the Secretary shall approve
11 such model for a demonstration program under this
12 subsection only if the Secretary determines the
13 model satisfies the criteria described in subsection
14 (d)(1)(B). The Secretary shall periodically make a
15 available a list of such models so approved.

16 “(3) PARTICIPATING ENTITIES.—To participate
17 under a demonstration program under this sub-
18 section, with respect to an Alternative Payment
19 Model, a physician, practitioner, or other supplier
20 shall enter into a contract with the Administrator of
21 the Centers for Medicare & Medicaid Services under
22 this subsection. For purposes of this section, such a
23 physician, practitioner, or supplier who so partici-
24 pates under such an Alternative Payment Model

1 shall be referred to as a ‘participating APM pro-
2 vider’.

3 “(4) REPORTING AND EVALUATION.—

4 “(A) INDEPENDENT EVALUATION ENTI-
5 TY.—Under this subsection, the Secretary shall
6 enter into a contract with an independent entity
7 to evaluate Alternative Payment Models under
8 demonstration programs under this subsection
9 based on appropriate measures specified under
10 subparagraph (B). In this section, such entity
11 shall be referred to as the ‘independent evalua-
12 tion entity’. Such contract shall be entered into
13 in a timely manner so as to ensure evaluation
14 of an Alternative Payment Model under a dem-
15 onstration program under this subsection may
16 begin as soon as possible after the model is ap-
17 proved under paragraph (2).

18 “(B) PERFORMANCE MEASURES.—For
19 purposes of this subsection, the Secretary shall
20 specify—

21 “(i) measures to evaluate Alternative
22 Payment Models under demonstration pro-
23 grams under this subsection, which may
24 include measures suggested under sub-
25 section (c) and shall be sufficient to allow

1 for a comprehensive assessment of such a
2 model; and

3 “(ii) quality measures on which par-
4 ticipating entities shall report, which shall
5 be similar to measures applicable under
6 section 1848(k).

7 “(C) REPORTING REQUIREMENTS.—A con-
8 tract entered into with a participating APM
9 provider under paragraph (3) shall require such
10 provider to report on appropriate measures
11 specified under subparagraph (B).

12 “(D) PERIODIC REVIEW.—The inde-
13 pendent evaluation entity shall periodically re-
14 view and analyze and submit such analysis to
15 the Secretary and the participating entities in-
16 volved data reported under subparagraph (C)
17 and such other data as deemed necessary to
18 evaluate the model.

19 “(E) FINAL EVALUATION.—Not later than
20 6 months after the date of completion of a dem-
21 onstration program, the independent evaluation
22 entity shall submit to the Secretary, the Medi-
23 care Payment Advisory Commission, and the
24 Chief Actuary of the Centers for Medicare &
25 Medicaid Services (and make publicly available)

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

3 “(i) outcomes on the clinical and
4 claims data received through such program
5 with respect to such model;

6 “(ii) recommendations on—

7 “(I) whether or not such model
8 should be implemented as an eligible
9 APM under this section; or

10 “(II) whether or not the evalua-
11 tion of such model under the dem-
12 onstration program should be ex-
13 tended or expanded;

14 “(iii) the justification for each such
15 recommendation described in clause (ii);
16 and

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

21 “(5) APPROVAL OF EXTENDING EVALUATION
22 UNDER DEMONSTRATION.—Not later than 90 days
23 after the date of receipt of a submission under para-
24 graph (4)(E), the Secretary shall, including based on
25 a recommendation submitted under such paragraph,

1 determine whether an Alternative Payment Model
2 may be extended or expanded under the demonstra-
3 tion program.

4 “(6) TERMINATION.—The Secretary shall ter-
5 minate a demonstration program for a model under
6 this subsection unless the Secretary determines (and
7 the Chief Actuary of the Centers for Medicare &
8 Medicaid Services, with respect to program spending
9 under this title, certifies), after testing has begun,
10 that the model is expected to—

11 “(A) improve the quality of care (as deter-
12 mined by the Administrator of the Centers for
13 Medicare & Medicaid Services) without increas-
14 ing spending under this title;

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

17 “(C) improve the quality of care and re-
18 duce spending.

19 Such termination may occur at any time after such
20 testing has begun and before completion of the test-
21 ing.

22 “(7) FUNDING.—

23 “(A) IN GENERAL.—There are appro-
24 priated, from amounts in the Federal Supple-
25 mentary Medical Insurance Trust Fund under

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

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

10 “(i) payments for items and services
11 furnished by participating entities under
12 an Alternative Payment Model under a
13 demonstration program under this sub-
14 section that—

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

17 “(II) exceed the amount of pay-
18 ment that would otherwise be made
19 for such items and services under this
20 title if such items and services were
21 not furnished under such demonstra-
22 tion program;

23 “(ii) the evaluations provided for
24 under this section of models under such a
25 demonstration program;

1 “(iii) payment to the contracting enti-
2 ty for carrying out its duties under this
3 section; and

4 “(iv) for otherwise carrying out this
5 subsection.

6 “(C) LIMITATION.—The amounts appro-
7 priated under subparagraph (A) are the only
8 amounts authorized or appropriated to carry
9 out the purposes described in subparagraph
10 (B).

11 “(f) IMPLEMENTATION OF RECOMMENDED MODELS
12 AS ELIGIBLE APMs.—

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

18 “(A) the Secretary determines that such
19 model is expected to—

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

22 “(ii) improve the quality of patient
23 care without increasing spending;

24 “(B) the Chief Actuary of the Centers for
25 Medicare & Medicaid Services certifies that

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

4 “(C) the Secretary determines that such
5 model would not deny or limit the coverage or
6 provision of benefits under this title for applica-
7 ble individuals.

8 Not later than 90 days after the date of issuance of
9 a proposed rule, with respect to an Alternative Pay-
10 ment Model, the Medicare Payment Advisory Com-
11 mission shall submit comments to Congress and the
12 Secretary evaluating the reports from the con-
13 tracting entity and independent evaluation entity on
14 such model regarding the model’s impact on expend-
15 itures and quality of care under this title.

16 “(2) APPLICABLE DATE.—For purposes of
17 paragraph (1), the applicable date under this para-
18 graph—

19 “(A) for an Alternative Payment Model
20 recommended under subsection (d)(1)(A)(ii) is
21 90 days after the date of submission of such
22 recommendation; and

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

1 is 90 days after the date of submission of such
2 recommendation

3 “(3) JUSTIFICATION FOR DISAPPROVALS.—In
4 the case that an Alternative Payment Model rec-
5 ommended under subsection (d)(1)(A)(ii) or
6 (e)(4)(E)(ii)(I) is not implemented as an eligible
7 APM under this subsection, the Secretary shall
8 make publicly available the rationale, in detail, for
9 such decision.

10 “(g) PERIODIC REVIEW AND TERMINATION.—

11 “(1) PERIODIC REVIEW.—In the case of an Al-
12 ternative Payment Model that has been imple-
13 mented, the Secretary and the Chief Actuary of the
14 Centers for Medicare & Medicaid Services shall re-
15 view such model every 3 years to determine (and
16 certify, in the case of the Chief Actuary and spend-
17 ing under this title), for the previous 3 years, wheth-
18 er the model has—

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

20 “(B) increased spending under this title,
21 compared to the quality of care or spending that
22 would have resulted if the model had not been imple-
23 mented.

24 “(2) TERMINATION.—

1 “(A) QUALITY OF CARE REDUCTION TER-
2 MINATION.—If based upon such review the Sec-
3 retary determines under paragraph (1)(A) that
4 the model has reduced the quality of care, the
5 Secretary may terminate such model.

6 “(B) SPENDING INCREASE TERMI-
7 NATION.—Unless such Chief Actuary certifies
8 under paragraph (1)(B) that the expenditures
9 under this title under the model do not exceed
10 the expenditures that would otherwise have
11 been made if the model had not been imple-
12 mented for the period involved, the Secretary
13 shall terminate such model.

14 “(h) DISSEMINATION OF ELIGIBLE APMS.—Under
15 this section there shall be established a process for speci-
16 fying, and making publicly available a list of, all eligible
17 APMs, which shall include at least those implemented
18 under subsection (f) and demonstrations carried out with
19 respect to payments under section 1848 through authority
20 in existence as of the day before the date of the enactment
21 of this section. Under such process such list shall be peri-
22 odically updated and, beginning with January 1, 2015,
23 and annually thereafter, such list shall be published in the
24 Federal Register.”.

1 (2) CONFORMING AMENDMENT.—Section
2 1848(a)(1) of the Social Security Act (42 U.S.C.
3 1395w-4(a)(1)) is amended by striking “shall in-
4 stead” and inserting “shall, subject to section
5 1848A, instead”.

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

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

9 (1) IN GENERAL.—To the extent consistent
10 with applicable information, privacy, security, and
11 disclosure laws, beginning with 2014, notwith-
12 standing the second sentence of paragraph (4)(D) of
13 section 1874(e) of the Social Security Act (42
14 U.S.C. 1395kk(e)), a qualified entity may use data
15 received by such entity under such section, and in-
16 formation derived from the evaluation described in
17 such paragraph (4)(D), for additional analyses (as
18 determined appropriate by the Secretary of Health
19 and Human Services) that such entity may provide
20 or sell to providers of services and suppliers (includ-
21 ing for the purposes of assisting providers of services
22 and suppliers to develop and participate in quality
23 and patient care improvement activities, including
24 developing new models of care).

25 (2) DEFINITIONS.—In this section:

1 (A) The term “qualified entity” has the
2 meaning given such term in section 1874(e)(2)
3 of the Social Security Act (42 U.S.C.
4 1395kk(e)).

5 (B) The terms “supplier” and “provider of
6 services” have the meanings given such terms
7 in subsections (d) and (u), respectively, of sec-
8 tion 1861 of the Social Security Act (42 U.S.C.
9 1395x).

10 (b) ACCESS TO MEDICARE DATA TO PROVIDERS OF
11 SERVICES AND SUPPLIERS TO FACILITATE DEVELOP-
12 MENT OF ALTERNATIVE PAYMENT MODELS AND TO
13 QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE
14 QUALITY IMPROVEMENT.—Consistent with applicable
15 laws and regulations with respect to privacy and other rel-
16 evant matters, the Secretary shall provide Medicare claims
17 data for non-public use (in a form and manner determined
18 to be appropriate) to—

19 (1) qualified entities, that may share with pro-
20 viders of services and suppliers that are registered or
21 authorized users or subscribers, in order to facilitate
22 the development of new models of care (including de-
23 velopment of Alternate Payment Models under sec-
24 tion 1848A of the Social Security Act, models for

1 small group specialty practices, and care coordina-
2 tion models); and

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

9 **SEC. 4. ENCOURAGING CARE COORDINATION AND MED-**
10 **ICAL HOMES.**

11 Section 1848(b) of the Social Security Act (42 U.S.C.
12 1395w-4(b)) is amended by adding at the end the fol-
13 lowing new paragraph:

14 “(8) **ENCOURAGING CARE COORDINATION AND**
15 **MEDICAL HOMES.—**

16 “(A) **IN GENERAL.—**In order to promote
17 the coordination of care by an applicable physi-
18 cian (as defined in subparagraph (B)) for indi-
19 viduals with complex chronic care needs who
20 are furnished items and services by multiple
21 physicians and other suppliers and providers of
22 services, the Secretary shall—

23 “(i) develop one or more HCPCS
24 codes for complex chronic care manage-

1 ment services for individuals with complex
2 chronic care needs; and

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

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

13 “(i) is certified as a medical home (by
14 achieving an accreditation status of level 3
15 by the National Committee for Quality As-
16 surance);

17 “(ii) is recognized as a patient-cen-
18 tered specialty practice by the National
19 Committee for Quality Assurance;

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

22 “(iv) meets such other comparable
23 qualifications as the Secretary determines
24 to be appropriate.

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

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

11 **SEC. 5. MISCELLANEOUS.**

12 (a) SOLICITATIONS, RECOMMENDATIONS, AND RE-
13 PORTS.—

14 (1) SOLICITATION FOR RECOMMENDATIONS ON
15 EPISODES OF CARE DEFINITION.—The Adminis-
16 trator of the Centers for Medicare & Medicaid Serv-
17 ices shall request eligible professional organizations
18 (as defined in section 1848(k)(3) of the Social Secu-
19 rity Act (42 U.S.C. 1395w-4(k)(3))) and other rel-
20 evant stakeholders to submit recommendations for
21 defining non-acute related episodes of care for pur-
22 poses of applying such definition under subsections
23 (k) and (q) of section 1848 of the Social Security
24 Act (42 U.S.C. 1395w-4) and section 1848A of such

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

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

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

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

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

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

1 Medicare & Medicaid Services a biannual
2 progress report—

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

11 (ii) that includes an evaluation of
12 such paragraph and such quality update
13 incentive program and recommendations
14 with respect to such program and appro-
15 priate update mechanisms; and

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

21 (B) GAO AND MEDPAC REPORTS.—

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

1 which the system under section 1848(k)(9)
2 of the Social Security Act (42 U.S.C.
3 1395w-4(k)(9)) and such quality update
4 incentive program under section 1848(q) of
5 the Social Security Act, as added by sec-
6 tion 2(b), as of such date, is successfully
7 satisfying performance objectives, including
8 with respect to—

9 (I) the process for developing and
10 selecting measures and activities
11 under subsection (k)(9) of section
12 1848 of such Act (42 U.S.C. 1395w-
13 4);

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

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

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

23 (I) GAO.—The Comptroller Gen-
24 eral of the United States shall evalu-
25 ate the initial phase of the quality up-

1 date incentive program under sub-
2 section (q) of section 1848 of the So-
3 cial Security Act (42 U.S.C. 1395w-
4 4) and shall submit to Congress, not
5 later than 2019, a report with rec-
6 ommendations for improving such
7 quality update incentive program.

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

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

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

1 the Medicare Payment Advisory Com-
2 mission shall examine at least the fol-
3 lowing models:

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

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

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

11 (dd) Gainsharing arrange-
12 ments

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

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

1 Internet website of the Centers for Medicare &
2 Medicaid Services annual reports on such top-
3 ics.

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

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

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

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

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

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

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

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

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

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

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

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

20 “(i) identify, based on the data re-
21 ported under paragraph (8) and other rel-
22 evant data, misvalued services for which
23 adjustments to the relative values estab-
24 lished under this paragraph would result in
25 a net reduction in expenditures under the

1 fee schedule under this section, with re-
2 spect to such year, of not more than 1 per-
3 cent of the projected amount of expendi-
4 tures under such fee schedule for such
5 year; and

6 “(ii) make such adjustments for each
7 such year so as to result in such a net re-
8 duction for such year.”.

9 (B) BUDGET NEUTRALITY.—Section
10 1848(c)(2)(B)(v) of the Social Security Act (42
11 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by
12 adding at the end the following new subclause:

13 “(VIII) REDUCTIONS FOR
14 MISVALUED PHYSICIANS’ SERVICES.—
15 Reduced expenditures attributable to
16 subparagraph (M).”.

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

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

1 (2) DEFINITIONS.—For purposes of this sub-
2 section:

3 (A) The term “Federal health care provi-
4 sion” means any provision of the Patient Pro-
5 tection and Affordable Care Act (Public Law
6 111–148), title I and subtitle B of title III of
7 the Health Care and Education Reconciliation
8 Act of 2010 (Public Law 111–152), and titles
9 XVIII and XIX of the Social Security Act.

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

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

15 (ii) required to be so licensed, reg-
16 istered, or certified but that is exempted
17 by other statute or regulation.

18 (C) The term “medical malpractice or
19 medical liability action or claim” means a med-
20 ical malpractice action or claim (as defined in
21 section 431(7) of the Health Care Quality Im-
22 provement Act of 1986 (42 U.S.C. 11151(7)))
23 and includes a liability action or claim relating
24 to a health care provider’s prescription or provi-
25 sion of a drug, device, or biological product (as

1 such terms are defined in section 201 of the
2 Federal Food, Drug, and Cosmetic Act or sec-
3 tion 351 of the Public Health Service Act).

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

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