

113TH CONGRESS  
2D SESSION

# S. 2000

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

FEBRUARY 6, 2014

Mr. BAUCUS (for himself and Mr. HATCH) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, 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       “SGR Repeal and Medicare Provider Payment Moderniza-  
6       tion Act of 2014”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians' services.
- Sec. 3. Priorities and funding for measure development.
- Sec. 4. Encouraging care management for individuals with chronic care needs.
- Sec. 5. Ensuring accurate valuation of services under the physician fee schedule.
- Sec. 6. Promoting evidence-based care.
- Sec. 7. Empowering beneficiary choices through access to information on physicians' services.
- Sec. 8. Expanding availability of Medicare data.
- Sec. 9. Reducing administrative burden and other provisions.

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

**4 (a) STABILIZING FEE UPDATES.—**

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

**8 (A) in subsection (d)—**

**9 (i) in paragraph (1)(A), by inserting**  
**10 “or a subsequent paragraph” after “para-**  
**11 graph (4)”;** and

**12 (ii) in paragraph (4)—**

**13 (I) in the heading, by inserting**  
**14 “AND ENDING WITH 2013” after**  
**15 “YEARS BEGINNING WITH 2001”;** and

**16 (II) in subparagraph (A), by in-**  
**17 serting “and ending with 2013” after**  
**18 “a year beginning with 2001”;** and

**19 (B) in subsection (f)—**

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

4 (ii) in paragraph (2), in the matter  
 5 preceding subparagraph (A), by inserting  
 6 “and ending with 2013” after “beginning  
 7 with 2000”.

8 (2) UPDATE OF RATES FOR APRIL THROUGH  
 9 DECEMBER OF 2014, 2015, AND SUBSEQUENT  
 10 YEARS.—Subsection (d) of section 1848 of the Social  
 11 Security Act (42 U.S.C. 1395w-4) is amended by  
 12 striking paragraph (15) and inserting the following  
 13 new paragraphs:

14 “(15) UPDATE FOR 2014 THROUGH 2018.—The  
 15 update to the single conversion factor established in  
 16 paragraph (1)(C) for 2014 and each subsequent  
 17 year through 2018 shall be 0.5 percent.

18 “(16) UPDATE FOR 2019 THROUGH 2023.—The  
 19 update to the single conversion factor established in  
 20 paragraph (1)(C) for 2019 and each subsequent  
 21 year through 2023 shall be zero percent.

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

“(A) for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) for such year, 1.0 percent; and

“(B) for other items and services, 0.5 percent.”.

(3) MEDPAC REPORTS.—

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

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

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

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns

on total utilization and expenditures under parts A, B, and D of such title.

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

(C) REPORT ON UPDATE TO PHYSICIANS' SERVICES UNDER MEDICARE.—Not later than July 1, 2018, the Medicare Payment Advisory Commission shall submit to Congress a report on—

(i) the payment update for professional services applied under the Medicare program under title XVIII of the Social Security Act for the period of years 2014 through 2018;

(ii) the effect of such update on the efficiency, economy, and quality of care provided under such program;

(iii) the effect of such update on ensuring a sufficient number of providers to

maintain access to care by Medicare beneficiaries; and

(iv) recommendations for any future payment updates for professional services under such program to ensure adequate access to care is maintained for Medicare beneficiaries.

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PERFORMANCE PROGRAMS WITH NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

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

(i) in clause (i), by striking “or any subsequent payment year” and inserting “or 2017”;

(ii) in clause (ii)—

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

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

1 (III) in subclause (II), by strik-  
 2 ing “; and” and inserting a period;  
 3 and  
 4 (IV) by striking subclause (III);  
 5 and  
 6 (iii) by striking clause (iii).

7 (B) CONTINUATION OF MEANINGFUL USE  
 8 DETERMINATIONS FOR MIPS.—Section  
 9 1848(o)(2) of the Social Security Act (42  
 10 U.S.C. 1395w-4(o)(2)) is amended—

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

13 (I) by striking “For purposes of  
 14 paragraph (1), an” and inserting  
 15 “An”; and

16 (II) by inserting “, or pursuant  
 17 to subparagraph (D) for purposes of  
 18 subsection (q), for a performance pe-  
 19 riod under such subsection for a year”  
 20 after “under such subsection for a  
 21 year”; and

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

24 “(D) CONTINUED APPLICATION FOR PUR-  
 25 POSES OF MIPS.—With respect to 2018 and

each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.”.

(2) QUALITY REPORTING.—

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

(i) in clause (i), by striking “or any subsequent year” and inserting “or 2017”; and

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

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

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



1 “(9) CONTINUED APPLICATION FOR PURPOSES  
 2 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-  
 3 TEERING TO REPORT.—The Secretary shall, in ac-  
 4 cordance with subsection (q)(1)(F), carry out the  
 5 provisions of this subsection—

6 “(A) for purposes of subsection (q); and

7 “(B) for eligible professionals who are not  
 8 MIPS eligible professionals (as defined in sub-  
 9 section (q)(1)(C)) for the year involved.”; and

10 (ii) in subsection (m)—

11 (I) by redesignating paragraph  
 12 (7) added by section 10327(a) of Pub-  
 13 lic Law 111–148 as paragraph (8);  
 14 and

15 (II) by adding at the end the fol-  
 16 lowing new paragraph:

17 “(9) CONTINUED APPLICATION FOR PURPOSES  
 18 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-  
 19 TEERING TO REPORT.—The Secretary shall, in ac-  
 20 cordance with subsection (q)(1)(F), carry out the  
 21 processes under this subsection—

22 “(A) for purposes of subsection (q); and

23 “(B) for eligible professionals who are not  
 24 MIPS eligible professionals (as defined in sub-  
 25 section (q)(1)(C)) for the year involved.”.

1 (3) VALUE-BASED PAYMENTS.—

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

7 “(iii) APPLICATION.—The Secretary  
8 shall apply the payment modifier estab-  
9 lished under this subsection for items and  
10 services furnished on or after January 1,  
11 2015, but before January 1, 2018, with re-  
12 spect to specific physicians and groups of  
13 physicians the Secretary determines appro-  
14 priate. Such payment modifier shall not be  
15 applied for items and services furnished on  
16 or after January 1, 2018.”.

17 (B) CONTINUATION OF VALUE-BASED PAY-  
18 MENT MODIFIER MEASURES FOR MIPS.—Section  
19 1848(p) of the Social Security Act (42 U.S.C.  
20 1395w–4(p)) is amended—

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

23 “(C) CONTINUED APPLICATION FOR PUR-  
24 POSES OF MIPS.—The Secretary shall, in ac-  
25 cordance with subsection (q)(1)(F), carry out

1           subparagraph (B) for purposes of subsection  
2           (q).”; and

3                       (ii) in paragraph (3), by adding at the  
4                       end the following: “With respect to 2018  
5                       and each subsequent year, the Secretary  
6                       shall, in accordance with subsection  
7                       (q)(1)(F), carry out this paragraph for  
8                       purposes of subsection (q).”.

9           (c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

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

13                   “(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

14                               “(1) ESTABLISHMENT.—

15                                       “(A) IN GENERAL.—Subject to the suc-  
16                                       ceeding provisions of this subsection, the Sec-  
17                                       retary shall establish an eligible professional  
18                                       Merit-based Incentive Payment System (in this  
19                                       subsection referred to as the ‘MIPS’) under  
20                                       which the Secretary shall—

21   “(i) develop a methodology for assess-  
22   ing the total performance of each MIPS el-  
23   igible professional according to perform-  
24   ance standards under paragraph (3) for a

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

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

“(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to determine and apply a MIPS adjustment factor (and, as applicable, an additional MIPS adjustment factor) under paragraph (6) to the professional for the year.

“(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2018.

“(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

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

“(I) for the first and second years for which the MIPS applies to

1 payments (and for the performance  
 2 period for such first and second year),  
 3 a physician (as defined in section  
 4 1861(r)), a physician assistant, nurse  
 5 practitioner, and clinical nurse spe-  
 6 cialist (as such terms are defined in  
 7 section 1861(aa)(5)), and a certified  
 8 registered nurse anesthetist (as de-  
 9 fined in section 1861(bb)(2)) and a  
 10 group that includes such profes-  
 11 sionals; and

12 “(II) for the third year for which  
 13 the MIPS applies to payments (and  
 14 for the performance period for such  
 15 third year) and for each succeeding  
 16 year (and for the performance period  
 17 for each such year), the professionals  
 18 described in subclause (I) and such  
 19 other eligible professionals (as defined  
 20 in subsection (k)(3)(B)) as specified  
 21 by the Secretary and a group that in-  
 22 cludes such professionals.

23 “(ii) EXCLUSIONS.—For purposes of  
 24 clause (i), the term ‘MIPS eligible profes-  
 25 sional’ does not include, with respect to a

1 year, an eligible professional (as defined in  
2 subsection (k)(3)(B)) who—

3 “(I) is a qualifying APM partici-  
4 pant (as defined in section  
5 1833(z)(2));

6 “(II) subject to clause (vii), is a  
7 partial qualifying APM participant (as  
8 defined in clause (iii)) for the most re-  
9 cent period for which data are avail-  
10 able and who, for the performance pe-  
11 riod with respect to such year, does  
12 not report on applicable measures and  
13 activities described in paragraph  
14 (2)(B) that are required to be re-  
15 ported by such a professional under  
16 the MIPS; or

17 “(III) for the performance period  
18 with respect to such year, does not ex-  
19 ceed the low-volume threshold meas-  
20 urement selected under clause (iv).

21 “(iii) PARTIAL QUALIFYING APM PAR-  
22 TICIPANT.—For purposes of this subpara-  
23 graph, the term ‘partial qualifying APM  
24 participant’ means, with respect to a year,  
25 an eligible professional for whom the Sec-

1           retary determines the minimum payment  
2           percentage (or percentages), as applicable,  
3           described in paragraph (2) of section  
4           1833(z) for such year have not been satis-  
5           fied, but who would be considered a quali-  
6           fying APM participant (as defined in such  
7           paragraph) for such year if—

8                   “(I) with respect to 2018 and  
9                   2019, the reference in subparagraph  
10                  (A) of such paragraph to 25 percent  
11                  was instead a reference to 20 percent;

12                  “(II) with respect to 2020 and  
13                  2021—

14                   “(aa) the reference in sub-  
15                   paragraph (B)(i) of such para-  
16                   graph to 50 percent was instead  
17                   a reference to 40 percent; and

18                   “(bb) the references in sub-  
19                   paragraph (B)(ii) of such para-  
20                   graph to 50 percent and 25 per-  
21                   cent of such paragraph were in-  
22                   stead references to 40 percent  
23                   and 20 percent, respectively; and

24                  “(III) with respect to 2022 and  
25                  subsequent years—

1                   “(aa) the reference in sub-  
2                   paragraph (C)(i) of such para-  
3                   graph to 75 percent was instead  
4                   a reference to 50 percent; and

5                   “(bb) the references in sub-  
6                   paragraph (C)(ii) of such para-  
7                   graph to 75 percent and 25 per-  
8                   cent of such paragraph were in-  
9                   stead references to 50 percent  
10                  and 20 percent, respectively.

11                  “(iv) SELECTION OF LOW-VOLUME  
12                  THRESHOLD MEASUREMENT.—The Sec-  
13                  retary shall select a low-volume threshold  
14                  to apply for purposes of clause (ii)(III),  
15                  which may include one or more or a com-  
16                  bination of the following:

17                  “(I) The minimum number (as  
18                  determined by the Secretary) of indi-  
19                  viduals enrolled under this part who  
20                  are treated by the eligible professional  
21                  for the performance period involved.

22                  “(II) The minimum number (as  
23                  determined by the Secretary) of items  
24                  and services furnished to individuals



1 enrolled under this part by such pro-  
2 fessional for such performance period.

3 “(III) The minimum amount (as  
4 determined by the Secretary) of al-  
5 lowed charges billed by such profes-  
6 sional under this part for such per-  
7 formance period.

8 “(v) TREATMENT OF NEW MEDICARE  
9 ENROLLED ELIGIBLE PROFESSIONALS.—In  
10 the case of a professional who first be-  
11 comes a Medicare enrolled eligible profes-  
12 sional during the performance period for a  
13 year (and had not previously submitted  
14 claims under this title such as a person, an  
15 entity, or a part of a physician group or  
16 under a different billing number or tax  
17 identifier), such professional shall not be  
18 treated under this subsection as a MIPS  
19 eligible professional until the subsequent  
20 year and performance period for such sub-  
21 sequent year.

22 “(vi) CLARIFICATION.—In the case of  
23 items and services furnished during a year  
24 by an individual who is not a MIPS eligible  
25 professional (including pursuant to clauses

(ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

“(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

“(I) TREATMENT AS MIPS ELIGIBLE PROFESSIONAL.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who for the performance period for such year reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

“(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect

1 to a year, be considered a qualifying  
 2 APM participant (as defined in para-  
 3 graph (2) of section 1833(z)) for such  
 4 year or be eligible for the additional  
 5 payment under paragraph (1) of such  
 6 section for such year.

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

9 “(i) IN GENERAL.—Under the MIPS:

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

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

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

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

13                  “(iii) CLARIFICATION.—MIPS eligible  
 14                  professionals electing to be a virtual group  
 15                  under paragraph (5)(I) shall not be consid-  
 16                  ered MIPS eligible professionals in a group  
 17                  practice for purposes of applying this sub-  
 18                  paragraph.

19                  “(E) USE OF REGISTRIES.—Under the  
 20                  MIPS, the Secretary shall encourage the use of  
 21                  qualified clinical data registries pursuant to  
 22                  subsection (m)(3)(E) in carrying out this sub-  
 23                  section.

24                  “(F) APPLICATION OF CERTAIN PROVI-  
 25                  SIONS.—In applying a provision of subsection

1 (k), (m), (o), or (p) for purposes of this sub-  
2 section, the Secretary shall—

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

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

10 “(G) ACCOUNTING FOR RISK FACTORS.—

11 “(i) RISK FACTORS.—Taking into ac-  
12 count the relevant studies conducted and  
13 recommendations made in reports under  
14 section 2(f)(1) of the SGR Repeal and  
15 Medicare Provider Payment Modernization  
16 Act of 2014, the Secretary, on an ongoing  
17 basis, shall estimate how an individual’s  
18 health status and other risk factors affect  
19 quality and resource use outcome measures  
20 and, as feasible, shall incorporate informa-  
21 tion from quality and resource use outcome  
22 measurement (including care episode and  
23 patient condition groups) into the MIPS.

24 “(ii) ACCOUNTING FOR OTHER FAC-  
25 TORS IN PAYMENT ADJUSTMENTS.—Tak-

ing into account the studies conducted and recommendations made in reports under section 2(f)(1) of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 and other information as appropriate, the Secretary shall account for identified factors with an effect on quality and resource use outcome measures when determining payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

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

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

“(i) Quality.

“(ii) Resource use.

“(iii) Clinical practice improvement activities.

1 “(iv) Meaningful use of certified EHR  
2 technology.

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

9 “(i) QUALITY.—For the performance  
10 category described in subparagraph (A)(i),  
11 the quality measures included in the final  
12 measures list published under subpara-  
13 graph (D)(i) for such year and the list of  
14 quality measures described in subpara-  
15 graph (D)(vi) used by qualified clinical  
16 data registries under subsection (m)(3)(E).

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

1 “(iii) CLINICAL PRACTICE IMPROVE-  
2 MENT ACTIVITIES.—For the performance  
3 category described in subparagraph  
4 (A)(iii), clinical practice improvement ac-  
5 tivities (as defined in subparagraph  
6 (C)(v)(III)) under subcategories specified  
7 by the Secretary for such period, which  
8 shall include at least the following:

9 “(I) The subcategory of expanded  
10 practice access, which shall include ac-  
11 tivities such as same day appoint-  
12 ments for urgent needs and after  
13 hours access to clinician advice.

14 “(II) The subcategory of popu-  
15 lation management, which shall in-  
16 clude activities such as monitoring  
17 health conditions of individuals to pro-  
18 vide timely health care interventions  
19 or participation in a qualified clinical  
20 data registry.

21 “(III) The subcategory of care  
22 coordination, which shall include ac-  
23 tivities such as timely communication  
24 of test results, timely exchange of  
25 clinical information to patients and



1 other providers, and use of remote  
2 monitoring or telehealth.

3 “(IV) The subcategory of bene-  
4 ficiary engagement, which shall in-  
5 clude activities such as the establish-  
6 ment of care plans for individuals  
7 with complex care needs, beneficiary  
8 self-management assessment and  
9 training, and using shared decision-  
10 making mechanisms.

11 “(V) The subcategory of patient  
12 safety and practice assessment, such  
13 as through use of clinical or surgical  
14 checklists and practice assessments  
15 related to maintaining certification.

16 “(VI) The subcategory of partici-  
17 pation in an alternative payment  
18 model (as defined in section  
19 1833(z)(3)(C)).

20 In establishing activities under this clause,  
21 the Secretary shall give consideration to  
22 the circumstances of small practices (con-  
23 sisting of 15 or fewer professionals) and  
24 practices located in rural areas and in  
25 health professional shortage areas (as des-

1           ignated under section 332(a)(1)(A) of the  
2           Public Health Service Act).

3           “(iv) MEANINGFUL EHR USE.—For  
4           the performance category described in sub-  
5           paragraph (A)(iv), the requirements estab-  
6           lished for such period under subsection  
7           (o)(2) for determining whether an eligible  
8           professional is a meaningful EHR user.

9           “(C) ADDITIONAL PROVISIONS.—

10          “(i) EMPHASIZING OUTCOME MEAS-  
11          URES UNDER THE QUALITY PERFORMANCE  
12          CATEGORY.—In applying subparagraph  
13          (B)(i), the Secretary shall, as feasible, em-  
14          phasize the application of outcome meas-  
15          ures.

16          “(ii) APPLICATION OF ADDITIONAL  
17          SYSTEM MEASURES.—The Secretary may  
18          use measures used for a payment system  
19          other than for physicians, such as meas-  
20          ures for inpatient hospitals, for purposes of  
21          the performance categories described in  
22          clauses (i) and (ii) of subparagraph (A).  
23          For purposes of the previous sentence, the  
24          Secretary may not use measures for hos-

1           pital outpatient departments, except in the  
2           case of emergency physicians.

3           “(iii) GLOBAL AND POPULATION-  
4           BASED MEASURES.—The Secretary may  
5           use global measures, such as global out-  
6           come measures, and population-based  
7           measures for purposes of the performance  
8           category described in subparagraph (A)(i).

9           “(iv) APPLICATION OF MEASURES AND  
10          ACTIVITIES TO NON-PATIENT-FACING PRO-  
11          FESSIONALS.—In carrying out this para-  
12          graph, with respect to measures and activi-  
13          ties specified in subparagraph (B) for per-  
14          formance categories described in subpara-  
15          graph (A), the Secretary—

16               “(I) shall give consideration to  
17               the circumstances of professional  
18               types (or subcategories of those types  
19               determined by practice characteris-  
20               tics) who typically furnish services  
21               that do not involve face-to-face inter-  
22               action with a patient; and

23               “(II) may, to the extent feasible  
24               and appropriate, take into account  
25               such circumstances and apply under

1           this subsection with respect to MIPS  
 2           eligible professionals of such profes-  
 3           sional types or subcategories, alter-  
 4           native measures or activities that ful-  
 5           fill the goals of the applicable per-  
 6           formance category.

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

10           “(v) CLINICAL PRACTICE IMPROVE-  
 11           MENT ACTIVITIES.—

12                   “(I) REQUEST FOR INFORMA-  
 13                   TION.—In initially applying subpara-  
 14                   graph (B)(iii), the Secretary shall use  
 15                   a request for information to solicit  
 16                   recommendations from stakeholders to  
 17                   identify activities described in such  
 18                   subparagraph and specifying criteria  
 19                   for such activities.

20                   “(II) CONTRACT AUTHORITY FOR  
 21                   CLINICAL PRACTICE IMPROVEMENT  
 22                   ACTIVITIES PERFORMANCE CAT-  
 23                   EGORY.—In applying subparagraph  
 24                   (B)(iii), the Secretary may contract

1 with entities to assist the Secretary  
2 in—

3 “(aa) identifying activities  
4 described in subparagraph  
5 (B)(iii);

6 “(bb) specifying criteria for  
7 such activities; and

8 “(cc) determining whether a  
9 MIPS eligible professional meets  
10 such criteria.

11 “(III) CLINICAL PRACTICE IM-  
12 PROVEMENT ACTIVITIES DEFINED.—

13 For purposes of this subsection, the  
14 term ‘clinical practice improvement  
15 activity’ means an activity that rel-  
16 evant eligible professional organiza-  
17 tions and other relevant stakeholders  
18 identify as improving clinical practice  
19 or care delivery and that the Sec-  
20 retary determines, when effectively ex-  
21 ecuted, is likely to result in improved  
22 outcomes.

23 “(D) ANNUAL LIST OF QUALITY MEASURES  
24 AVAILABLE FOR MIPS ASSESSMENT.—

1           “(i) IN GENERAL.—Under the MIPS,  
2           the Secretary, through notice and comment  
3           rulemaking and subject to the succeeding  
4           clauses of this subparagraph, shall, with  
5           respect to the performance period for a  
6           year, establish an annual final list of qual-  
7           ity measures from which MIPS eligible  
8           professionals may choose for purposes of  
9           assessment under this subsection for such  
10          performance period. Pursuant to the pre-  
11          vious sentence, the Secretary shall—

12                   “(I) not later than November 1  
13                   of the year prior to the first day of  
14                   the first performance period under the  
15                   MIPS, establish and publish in the  
16                   Federal Register a final list of quality  
17                   measures; and

18                   “(II) not later than November 1  
19                   of the year prior to the first day of  
20                   each subsequent performance period,  
21                   update the final list of quality meas-  
22                   ures from the previous year (and pub-  
23                   lish such updated final list in the Fed-  
24                   eral Register), by—

1 “(aa) removing from such  
 2 list, as appropriate, quality meas-  
 3 ures, which may include the re-  
 4 moval of measures that are no  
 5 longer meaningful (such as meas-  
 6 ures that are topped out);

7 “(bb) adding to such list, as  
 8 appropriate, new quality meas-  
 9 ures; and

10 “(cc) determining whether  
 11 or not quality measures on such  
 12 list that have undergone sub-  
 13 stantive changes should be in-  
 14 cluded in the updated list.

15 “(ii) CALL FOR QUALITY MEAS-  
 16 URES.—

17 “(I) IN GENERAL.—Eligible pro-  
 18 fessional organizations and other rel-  
 19 evant stakeholders shall be requested  
 20 to identify and submit quality meas-  
 21 ures to be considered for selection  
 22 under this subparagraph in the an-  
 23 nual list of quality measures published  
 24 under clause (i) and to identify and  
 25 submit updates to the measures on

1 such list. For purposes of the previous  
 2 sentence, measures may be submitted  
 3 regardless of whether such measures  
 4 were previously published in a pro-  
 5 posed rule or endorsed by an entity  
 6 with a contract under section 1890(a).

7 “(II) ELIGIBLE PROFESSIONAL  
 8 ORGANIZATION DEFINED.—In this  
 9 subparagraph, the term ‘eligible pro-  
 10 fessional organization’ means a pro-  
 11 fessional organization as defined by  
 12 nationally recognized multispecialty  
 13 boards of certification or equivalent  
 14 certification boards.

15 “(iii) REQUIREMENTS.—In selecting  
 16 quality measures for inclusion in the an-  
 17 nual final list under clause (i), the Sec-  
 18 retary shall—

19 “(I) provide that, to the extent  
 20 practicable, all quality domains (as  
 21 defined in subsection (s)(1)(B)) are  
 22 addressed by such measures; and

23 “(II) ensure that such selection  
 24 is consistent with the process for se-



1                   lection of measures under subsections  
2                   (k), (m), and (p)(2).

3                   “(iv) PEER REVIEW.—Before includ-  
4                   ing a new measure or a measure described  
5                   in clause (i)(II)(cc) in the final list of  
6                   measures published under clause (i) for a  
7                   year, the Secretary shall submit for publi-  
8                   cation in applicable specialty-appropriate  
9                   peer-reviewed journals such measure and  
10                  the method for developing and selecting  
11                  such measure, including clinical and other  
12                  data supporting such measure.

13                  “(v) MEASURES FOR INCLUSION.—  
14                  The final list of quality measures published  
15                  under clause (i) shall include, as applica-  
16                  ble, measures under subsections (k), (m),  
17                  and (p)(2), including quality measures  
18                  from among—

19                         “(I) measures endorsed by a con-  
20                         sensus-based entity;

21                         “(II) measures developed under  
22                         subsection (s); and

23                         “(III) measures submitted under  
24                         clause (ii)(I).

1 Any measure selected for inclusion in such  
2 list that is not endorsed by a consensus-  
3 based entity shall have a focus that is evi-  
4 dence-based.

5 “(vi) EXCEPTION FOR QUALIFIED  
6 CLINICAL DATA REGISTRY MEASURES.—  
7 Measures used by a qualified clinical data  
8 registry under subsection (m)(3)(E) shall  
9 not be subject to the requirements under  
10 clauses (i), (iv), and (v). The Secretary  
11 shall publish the list of measures used by  
12 such qualified clinical data registries on  
13 the Internet website of the Centers for  
14 Medicare & Medicaid Services.

15 “(vii) EXCEPTION FOR EXISTING  
16 QUALITY MEASURES.—Any quality meas-  
17 ure specified by the Secretary under sub-  
18 section (k) or (m), including under sub-  
19 section (m)(3)(E), and any measure of  
20 quality of care established under sub-  
21 section (p)(2) for the reporting period  
22 under the respective subsection beginning  
23 before the first performance period under  
24 the MIPS—

1 “(I) shall not be subject to the  
 2 requirements under clause (i) (except  
 3 under items (aa) and (cc) of subclause  
 4 (II) of such clause) or to the require-  
 5 ment under clause (iv); and

6 “(II) shall be included in the  
 7 final list of quality measures pub-  
 8 lished under clause (i) unless removed  
 9 under clause (i)(II)(aa).

10 “(viii) CONSULTATION WITH REL-  
 11 EVANT ELIGIBLE PROFESSIONAL ORGANI-  
 12 ZATIONS AND OTHER RELEVANT STAKE-  
 13 HOLDERS.—Relevant eligible professional  
 14 organizations and other relevant stake-  
 15 holders, including State and national med-  
 16 ical societies, shall be consulted in carrying  
 17 out this subparagraph.

18 “(ix) OPTIONAL APPLICATION.—The  
 19 process under section 1890A is not re-  
 20 quired to apply to the selection of meas-  
 21 ures under this subparagraph.

22 “(3) PERFORMANCE STANDARDS.—

23 “(A) ESTABLISHMENT.—Under the MIPS,  
 24 the Secretary shall establish performance stand-  
 25 ards with respect to measures and activities

1 specified under paragraph (2)(B) for a perform-  
 2 ance period (as established under paragraph  
 3 (4)) for a year.

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

9 “(i) Historical performance standards.

10 “(ii) Improvement.

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

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

22 “(5) COMPOSITE PERFORMANCE SCORE.—

23 “(A) IN GENERAL.—Subject to the suc-  
 24 ceeding provisions of this paragraph and taking  
 25 into account, as available and applicable, para-

graph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the ‘composite performance score’ for such professional for such performance period.

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

“(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible profes-

1           sional who fails to report on an applicable  
2           measure or activity that is required to be  
3           reported by the professional, the profes-  
4           sional shall be treated as achieving the  
5           lowest potential score applicable to such  
6           measure or activity.

7           “(ii) ENCOURAGING USE OF CER-  
8           TIFIED EHR TECHNOLOGY AND QUALIFIED  
9           CLINICAL DATA REGISTRIES FOR REPORT-  
10          ING QUALITY MEASURES.—Under the  
11          methodology established under subpara-  
12          graph (A), the Secretary shall—

13               “(I) encourage MIPS eligible  
14               professionals to report on applicable  
15               measures with respect to the perform-  
16               ance category described in paragraph  
17               (2)(A)(i) through the use of certified  
18               EHR technology and qualified clinical  
19               data registries; and

20               “(II) with respect to a perform-  
21               ance period, with respect to a year,  
22               for which a MIPS eligible professional  
23               reports such measures through the  
24               use of such EHR technology, treat  
25               such professional as satisfying the

1 clinical quality measures reporting re-  
 2 quirement described in subsection  
 3 (o)(2)(A)(iii) for such year.

4 “(C) CLINICAL PRACTICE IMPROVEMENT  
 5 ACTIVITIES PERFORMANCE SCORE.—

6 “(i) RULE FOR ACCREDITATION.—A  
 7 MIPS eligible professional who is in a  
 8 practice that is certified as a patient-cen-  
 9 tered medical home or comparable spe-  
 10 cialty practice pursuant to subsection  
 11 (b)(8)(B)(i) with respect to a performance  
 12 period shall be given the highest potential  
 13 score for the performance category de-  
 14 scribed in paragraph (2)(A)(iii) for such  
 15 period.

16 “(ii) APM PARTICIPATION.—Partici-  
 17 pation by a MIPS eligible professional in  
 18 an alternative payment model (as defined  
 19 in section 1833(z)(3)(C)) with respect to a  
 20 performance period shall earn such eligible  
 21 professional a minimum score of one-half  
 22 of the highest potential score for the per-  
 23 formance category described in paragraph  
 24 (2)(A)(iii) for such performance period.

“(iii) SUBCATEGORIES.—A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

“(D) ACHIEVEMENT AND IMPROVEMENT.—

“(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the MIPS applies, in addition to the achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

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

“(II) in the case of performance scores for other performance cat-



1                   egories, may take into account the im-  
 2                   provement of the professional.

3                   “(ii) ASSIGNING HIGHER WEIGHT FOR  
 4                   ACHIEVEMENT.—Beginning with the  
 5                   fourth year to which the MIPS applies,  
 6                   under the methodology developed under  
 7                   subparagraph (A), the Secretary may as-  
 8                   sign a higher scoring weight under sub-  
 9                   paragraph (F) with respect to the achieve-  
 10                  ment of a MIPS eligible professional than  
 11                  with respect to any improvement of such  
 12                  professional applied under clause (i) with  
 13                  respect to a measure, activity, or category  
 14                  described in paragraph (2).

15                  “(E) WEIGHTS FOR THE PERFORMANCE  
 16                  CATEGORIES.—

17                  “(i) IN GENERAL.—Under the meth-  
 18                  odology developed under subparagraph (A),  
 19                  subject to subparagraph (F)(i) and clauses  
 20                  (ii) and (iii), the composite performance  
 21                  score shall be determined as follows:

22                          “(I) QUALITY.—

23                                  “(aa) IN GENERAL.—Sub-  
 24                                  ject to item (bb), thirty percent  
 25                                  of such score shall be based on

1 performance with respect to the  
2 category described in clause (i) of  
3 paragraph (2)(A). In applying  
4 the previous sentence, the Sec-  
5 retary shall, as feasible, encour-  
6 age the application of outcome  
7 measures within such category.

8 “(bb) FIRST 2 YEARS.—For  
9 the first and second years for  
10 which the MIPS applies to pay-  
11 ments, the percentage applicable  
12 under item (aa) shall be in-  
13 creased in a manner such that  
14 the total percentage points of the  
15 increase under this item for the  
16 respective year equals the total  
17 number of percentage points by  
18 which the percentage applied  
19 under subclause (II)(bb) for the  
20 respective year is less than 30  
21 percent.

22 “(II) RESOURCE USE.—

23 “(aa) IN GENERAL.—Sub-  
24 ject to item (bb), thirty percent  
25 of such score shall be based on

1 performance with respect to the  
2 category described in clause (ii)  
3 of paragraph (2)(A).

4 “(bb) FIRST 2 YEARS.—For  
5 the first year for which the MIPS  
6 applies to payments, not more  
7 than 10 percent of such score  
8 shall be based on performance  
9 with respect to the category de-  
10 scribed in clause (ii) of para-  
11 graph (2)(A). For the second  
12 year for which the MIPS applies  
13 to payments, not more than 15  
14 percent of such score shall be  
15 based on performance with re-  
16 spect to the category described in  
17 clause (ii) of paragraph (2)(A).

18 “(III) CLINICAL PRACTICE IM-  
19 PROVEMENT ACTIVITIES.—Fifteen  
20 percent of such score shall be based  
21 on performance with respect to the  
22 category described in clause (iii) of  
23 paragraph (2)(A).

24 “(IV) MEANINGFUL USE OF CER-  
25 TIFIED EHR TECHNOLOGY.—Twenty-

1 five percent of such score shall be  
2 based on performance with respect to  
3 the category described in clause (iv) of  
4 paragraph (2)(A).

5 “(ii) AUTHORITY TO ADJUST PER-  
6 CENTAGES IN CASE OF HIGH EHR MEAN-  
7 INGFUL USE ADOPTION.—In any year in  
8 which the Secretary estimates that the pro-  
9 portion of eligible professionals (as defined  
10 in subsection (o)(5)) who are meaningful  
11 EHR users (as determined under sub-  
12 section (o)(2)) is 75 percent or greater, the  
13 Secretary may reduce the percent applica-  
14 ble under clause (i)(IV), but not below 15  
15 percent. If the Secretary makes such re-  
16 duction for a year, subject to subclauses  
17 (I)(bb) and (II)(bb) of clause (i), the per-  
18 centages applicable under one or more of  
19 subclauses (I), (II), and (III) of clause (i)  
20 for such year shall be increased in a man-  
21 ner such that the total percentage points  
22 of the increase under this clause for such  
23 year equals the total number of percentage  
24 points reduced under the preceding sen-  
25 tence for such year.

1                   “(F)     CERTAIN     FLEXIBILITY     FOR  
 2                   WEIGHTING PERFORMANCE CATEGORIES, MEAS-  
 3                   URES, AND ACTIVITIES.—Under the method-  
 4                   ology under subparagraph (A), if there are not  
 5                   sufficient measures and clinical practice im-  
 6                   provement activities applicable and available to  
 7                   each type of eligible professional involved, the  
 8                   Secretary shall assign different scoring weights  
 9                   (including a weight of 0)—

10                   “(i) which may vary from the scoring  
 11                   weights specified in subparagraph (E), for  
 12                   each performance category based on the  
 13                   extent to which the category is applicable  
 14                   to the type of eligible professional involved;  
 15                   and

16                   “(ii) for each measure and activity  
 17                   specified under paragraph (2)(B) with re-  
 18                   spect to each such category based on the  
 19                   extent to which the measure or activity is  
 20                   applicable and available to the type of eli-  
 21                   gible professional involved.

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

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

“(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

“(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

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

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

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

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

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

1 professional or all such MIPS eligible profes-  
2 sionals in such group practice, respectively,  
3 to be a virtual group under this subpara-  
4 graph with at least one other such indi-  
5 vidual MIPS eligible professional or group  
6 practice making such an election. Such a  
7 virtual group may be based on geographic  
8 areas or on provider specialties defined by  
9 nationally recognized multispecialty boards  
10 of certification or equivalent certification  
11 boards and such other eligible professional  
12 groupings in order to capture classifica-  
13 tions of providers across eligible profes-  
14 sional organizations and other practice  
15 areas or categories.

16 “(iii) REQUIREMENTS.—The process  
17 under clause (ii)—

18 “(I) shall provide that an election  
19 under such clause, with respect to a  
20 performance period, shall be made be-  
21 fore or during the beginning of such  
22 performance period and may not be  
23 changed during such performance pe-  
24 riod;



1 “(II) shall provide that a practice  
 2 described in such clause, and each  
 3 MIPS eligible professional in such  
 4 practice, may elect to be in no more  
 5 than one virtual group for a perform-  
 6 ance period; and

7 “(III) may provide that a virtual  
 8 group may be combined at the tax  
 9 identification number level.

10 “(6) MIPS PAYMENTS.—

11 “(A) MIPS ADJUSTMENT FACTOR.—Tak-  
 12 ing into account paragraph (1)(G), the Sec-  
 13 retary shall specify a MIPS adjustment factor  
 14 for each MIPS eligible professional for a year.  
 15 Such MIPS adjustment factor for a MIPS eligi-  
 16 ble professional for a year shall be in the form  
 17 of a percent and shall be determined—

18 “(i) by comparing the composite per-  
 19 formance score of the eligible professional  
 20 for such year to the performance threshold  
 21 established under subparagraph (D)(i) for  
 22 such year;

23 “(ii) in a manner such that the ad-  
 24 justment factors specified under this sub-  
 25 paragraph for a year result in differential

1 payments under this paragraph reflecting  
2 that—

3 “(I) MIPS eligible professionals  
4 with composite performance scores for  
5 such year at or above such perform-  
6 ance threshold for such year receive  
7 zero or positive incentive payment ad-  
8 justment factors for such year in ac-  
9 cordance with clause (iii), with such  
10 professionals having higher composite  
11 performance scores receiving higher  
12 adjustment factors; and

13 “(II) MIPS eligible professionals  
14 with composite performance scores for  
15 such year below such performance  
16 threshold for such year receive nega-  
17 tive payment adjustment factors for  
18 such year in accordance with clause  
19 (iv), with such professionals having  
20 lower composite performance scores  
21 receiving lower adjustment factors;

22 “(iii) in a manner such that MIPS eli-  
23 gible professionals with composite scores  
24 described in clause (ii)(I) for such year,  
25 subject to clauses (i) and (ii) of subpara-

graph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

“(iv) in a manner such that—

“(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

“(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than  $\frac{1}{4}$  of the per-

1                   formance threshold specified under  
 2                   subparagraph (D)(i) for such year, re-  
 3                   ceive a negative payment adjustment  
 4                   factor that is equal to the negative of  
 5                   the applicable percent specified in  
 6                   subparagraph (B) for such year.

7                   “(B) APPLICABLE PERCENT DEFINED.—  
 8                   For purposes of this paragraph, the term ‘ap-  
 9                   plicable percent’ means—

10                   “(i) for 2018, 4 percent;

11                   “(ii) for 2019, 5 percent;

12                   “(iii) for 2020, 7 percent; and

13                   “(iv) for 2021 and subsequent years,  
 14                   9 percent.

15                   “(C) ADDITIONAL MIPS ADJUSTMENT FAC-  
 16                   TORS FOR EXCEPTIONAL PERFORMANCE.—

17                   “(i) IN GENERAL.—In the case of a  
 18                   MIPS eligible professional with a com-  
 19                   posite performance score for a year at or  
 20                   above the additional performance threshold  
 21                   under subparagraph (D)(ii) for such year,  
 22                   in addition to the MIPS adjustment factor  
 23                   under subparagraph (A) for the eligible  
 24                   professional for such year, subject to the  
 25                   availability of funds under clause (ii), the

Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

“(ii) ADDITIONAL FUNDING POOL.—  
For 2018 and each subsequent year through 2023, there is appropriated from the Federal Supplementary Medical Insurance Trust Fund \$500,000,000 for MIPS payments under this paragraph resulting from the application of the additional MIPS adjustment factors under clause (i).

“(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

“(i) PERFORMANCE THRESHOLD.—  
For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of

1 determining adjustment factors under sub-  
2 paragraph (A) that are positive, negative,  
3 and zero. Such performance threshold for  
4 a year shall be the mean or median (as se-  
5 lected by the Secretary) of the composite  
6 performance scores for all MIPS eligible  
7 professionals with respect to a prior period  
8 specified by the Secretary. The Secretary  
9 may reassess the selection under the pre-  
10 vious sentence every 3 years.

11 “(ii) ADDITIONAL PERFORMANCE  
12 THRESHOLD FOR EXCEPTIONAL PERFORM-  
13 ANCE.—In addition to the performance  
14 threshold under clause (i), for each year of  
15 the MIPS, the Secretary shall compute an  
16 additional performance threshold for pur-  
17 poses of determining the additional MIPS  
18 adjustment factors under subparagraph  
19 (C)(i). For each such year, the Secretary  
20 shall apply either of the following methods  
21 for computing such additional performance  
22 threshold for such a year:

23 “(I) The threshold shall be the  
24 score that is equal to the 25th per-  
25 centile of the range of possible com-

1           posite performance scores above the  
2           performance threshold with respect to  
3           the prior period described in clause  
4           (i).

5                   “(II) The threshold shall be the  
6           score that is equal to the 25th per-  
7           centile of the actual composite per-  
8           formance scores for MIPS eligible  
9           professionals with composite perform-  
10          ance scores at or above the perform-  
11          ance threshold with respect to the  
12          prior period described in clause (i).

13                   “(iii) SPECIAL RULE FOR INITIAL 2  
14          YEARS.—With respect to each of the first  
15          two years to which the MIPS applies, the  
16          Secretary shall, prior to the performance  
17          period for such years, establish a perform-  
18          ance threshold for purposes of determining  
19          MIPS adjustment factors under subpara-  
20          graph (A) and a threshold for purposes of  
21          determining additional MIPS adjustment  
22          factors under subparagraph (C)(i). Each  
23          such performance threshold shall—

24                   “(I) be based on a period prior to  
25                   such performance periods; and

1 “(II) take into account—

2 “(aa) data available with re-  
3 spect to performance on meas-  
4 ures and activities that may be  
5 used under the performance cat-  
6 egories under subparagraph  
7 (2)(B); and

8 “(bb) other factors deter-  
9 mined appropriate by the Sec-  
10 retary.

11 “(E) APPLICATION OF MIPS ADJUSTMENT  
12 FACTORS.—In the case of items and services  
13 furnished by a MIPS eligible professional dur-  
14 ing a year (beginning with 2018), the amount  
15 otherwise paid under this part with respect to  
16 such items and services and MIPS eligible pro-  
17 fessional for such year, shall be multiplied by—

18 “(i) 1, plus

19 “(ii) the sum of—

20 “(I) the MIPS adjustment factor  
21 determined under subparagraph (A)  
22 divided by 100, and

23 “(II) as applicable, the additional  
24 MIPS adjustment factor determined



1 under subparagraph (C)(i) divided by  
2 100.

3 “(F) AGGREGATE APPLICATION OF MIPS  
4 ADJUSTMENT FACTORS.—

5 “(i) APPLICATION OF SCALING FAC-  
6 TOR.—

7 “(I) IN GENERAL.—With respect  
8 to positive MIPS adjustment factors  
9 under subparagraph (A)(ii)(I) for eli-  
10 gible professionals whose composite  
11 performance score is above the per-  
12 formance threshold under subpara-  
13 graph (D)(i) for such year, subject to  
14 subclause (II), the Secretary shall in-  
15 crease or decrease such adjustment  
16 factors by a scaling factor in order to  
17 ensure that the budget neutrality re-  
18 quirement of clause (ii) is met.

19 “(II) SCALING FACTOR LIMIT.—  
20 In no case may be the scaling factor  
21 applied under this clause exceed 3.0.

22 “(ii) BUDGET NEUTRALITY REQUIRE-  
23 MENT.—

24 “(I) IN GENERAL.—Subject to  
25 clause (iii), the Secretary shall ensure

1 that the estimated amount described  
2 in subclause (II) for a year is equal to  
3 the estimated amount described in  
4 subclause (III) for such year.

5 “(II) AGGREGATE INCREASES.—

6 The amount described in this sub-  
7 clause is the estimated increase in the  
8 aggregate allowed charges resulting  
9 from the application of positive MIPS  
10 adjustment factors under subpara-  
11 graph (A) (after application of the  
12 scaling factor described in clause (i))  
13 to MIPS eligible professionals whose  
14 composite performance score for a  
15 year is above the performance thresh-  
16 old under subparagraph (D)(i) for  
17 such year.

18 “(III) AGGREGATE DE-

19 CREASES.—The amount described in  
20 this subclause is the estimated de-  
21 crease in the aggregate allowed  
22 charges resulting from the application  
23 of negative MIPS adjustment factors  
24 under subparagraph (A) to MIPS eli-  
25 gible professionals whose composite

performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

“(iii) EXCEPTIONS.—

“(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) shall not apply for such year.

“(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

“(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—In specifying the

1 MIPS additional adjustment factors under  
2 subparagraph (C)(i) for each applicable  
3 MIPS eligible professional for a year, the  
4 Secretary shall ensure that the estimated  
5 increase in payments under this part re-  
6 sulting from the application of such addi-  
7 tional adjustment factors for MIPS eligible  
8 professionals in a year shall be equal (as  
9 estimated by the Secretary) to the addi-  
10 tional funding pool amount for such year  
11 under subparagraph (C)(ii).

12 “(7) ANNOUNCEMENT OF RESULT OF ADJUST-  
13 MENTS.—Under the MIPS, the Secretary shall, not  
14 later than 30 days prior to January 1 of the year  
15 involved, make available to MIPS eligible profes-  
16 sionals the MIPS adjustment factor (and, as appli-  
17 cable, the additional MIPS adjustment factor) under  
18 paragraph (6) applicable to the eligible professional  
19 for items and services furnished by the professional  
20 for such year. The Secretary may include such infor-  
21 mation in the confidential feedback under paragraph  
22 (12).

23 “(8) NO EFFECT IN SUBSEQUENT YEARS.—The  
24 MIPS adjustment factors and additional MIPS ad-  
25 justment factors under paragraph (6) shall apply

1       only with respect to the year involved, and the Sec-  
2       retary shall not take into account such adjustment  
3       factors in making payments to a MIPS eligible pro-  
4       fessional under this part in a subsequent year.

5               “(9) PUBLIC REPORTING.—

6               “(A) IN GENERAL.—The Secretary shall,  
7       in an easily understandable format, make avail-  
8       able on the Physician Compare Internet website  
9       of the Centers for Medicare & Medicaid Serv-  
10      ices the following:

11              “(i) Information regarding the per-  
12      formance of MIPS eligible professionals  
13      under the MIPS, which—

14              “(I) shall include the composite  
15      score for each such MIPS eligible pro-  
16      fessional and the performance of each  
17      such MIPS eligible professional with  
18      respect to each performance category;  
19      and

20              “(II) may include the perform-  
21      ance of each such MIPS eligible pro-  
22      fessional with respect to each measure  
23      or activity specified in paragraph  
24      (2)(B).

1                   “(ii) The names of eligible profes-  
2                   sionals in eligible alternative payment mod-  
3                   els (as defined in section 1833(z)(3)(D))  
4                   and, to the extent feasible, the names of  
5                   such eligible alternative payment models  
6                   and performance of such models.

7                   “(B) DISCLOSURE.—The information  
8                   made available under this paragraph shall indi-  
9                   cate, where appropriate, that publicized infor-  
10                  mation may not be representative of the eligible  
11                  professional’s entire patient population, the va-  
12                  riety of services furnished by the eligible profes-  
13                  sional, or the health conditions of individuals  
14                  treated.

15                  “(C) OPPORTUNITY TO REVIEW AND SUB-  
16                  MIT CORRECTIONS.—The Secretary shall pro-  
17                  vide for an opportunity for a professional de-  
18                  scribed in subparagraph (A) to review, and sub-  
19                  mit corrections for, the information to be made  
20                  public with respect to the professional under  
21                  such subparagraph prior to such information  
22                  being made public.

23                  “(D) AGGREGATE INFORMATION.—The  
24                  Secretary shall periodically post on the Physi-  
25                  cian Compare Internet website aggregate infor-

1 mation on the MIPS, including the range of  
2 composite scores for all MIPS eligible profes-  
3 sionals and the range of the performance of all  
4 MIPS eligible professionals with respect to each  
5 performance category.

6 “(10) CONSULTATION.—The Secretary shall  
7 consult with stakeholders in carrying out the MIPS,  
8 including for the identification of measures and ac-  
9 tivities under paragraph (2)(B) and the methodolo-  
10 gies developed under paragraphs (5)(A) and (6) and  
11 regarding the use of qualified clinical data registries.  
12 Such consultation shall include the use of a request  
13 for information or other mechanisms determined ap-  
14 propriate.

15 “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-  
16 TICES AND PRACTICES IN HEALTH PROFESSIONAL  
17 SHORTAGE AREAS.—

18 “(A) IN GENERAL.—The Secretary shall  
19 enter into contracts or agreements with appro-  
20 priate entities (such as quality improvement or-  
21 ganizations, regional extension centers (as de-  
22 scribed in section 3012(c) of the Public Health  
23 Service Act), or regional health collaboratives)  
24 to offer guidance and assistance to MIPS eligi-  
25 ble professionals in practices of 15 or fewer pro-

professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

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

“(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

“(B) FUNDING FOR IMPLEMENTATION.—

“(i) IN GENERAL.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of \$40,000,000 for each of fiscal years 2015 through 2019. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.



1                   “(ii) TECHNICAL ASSISTANCE.—Of  
2                   the amounts transferred pursuant to clause  
3                   (i) for each of fiscal years 2015 through  
4                   2019, not less than \$10,000,000 shall be  
5                   made available for each such year for tech-  
6                   nical assistance to small practices in health  
7                   professional shortage areas (as so des-  
8                   ignated) and medically underserved areas.

9                   “(12) FEEDBACK AND INFORMATION TO IM-  
10                  PROVE PERFORMANCE.—

11                  “(A) PERFORMANCE FEEDBACK.—

12                   “(i) IN GENERAL.—Beginning July 1,  
13                   2016, the Secretary—

14                   “(I) shall make available timely  
15                   (such as quarterly) confidential feed-  
16                   back to MIPS eligible professionals on  
17                   the performance of such professionals  
18                   with respect to the performance cat-  
19                   egories under clauses (i) and (ii) of  
20                   paragraph (2)(A); and

21                   “(II) may make available con-  
22                   fidential feedback to each such profes-  
23                   sional on the performance of such  
24                   professional with respect to the per-

1 performance categories under clauses (iii)  
2 and (iv) of such paragraph.

3 “(ii) MECHANISMS.—The Secretary  
4 may use one or more mechanisms to make  
5 feedback available under clause (i), which  
6 may include use of a web-based portal or  
7 other mechanisms determined appropriate  
8 by the Secretary. With respect to the per-  
9 formance category described in paragraph  
10 (2)(A)(i), feedback under this subpara-  
11 graph shall, to the extent an eligible pro-  
12 fessional chooses to participate in a data  
13 registry for purposes of this subsection (in-  
14 cluding registries under subsections (k)  
15 and (m)), be provided based on perform-  
16 ance on quality measures reported through  
17 the use of such registries. With respect to  
18 any other performance category described  
19 in paragraph (2)(A), the Secretary shall  
20 encourage provision of feedback through  
21 qualified clinical data registries as de-  
22 scribed in subsection (m)(3)(E)).

23 “(iii) USE OF DATA.—For purposes of  
24 clause (i), the Secretary may use data,  
25 with respect to a MIPS eligible profes-

sional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

“(iv) DISCLOSURE EXEMPTION.— Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

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

“(B) ADDITIONAL INFORMATION.—

“(i) IN GENERAL.—Beginning July 1, 2017, the Secretary shall make available to each MIPS eligible professional information, with respect to individuals who are patients of such MIPS eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may

1 include information described in clause (ii).  
2 Such information may be made available  
3 under the previous sentence to such MIPS  
4 eligible professionals by mechanisms deter-  
5 mined appropriate by the Secretary, which  
6 may include use of a web-based portal.  
7 Such information may be made available in  
8 accordance with the same or similar terms  
9 as data are made available to accountable  
10 care organizations participating in the  
11 shared savings program under section  
12 1899, including a beneficiary opt-out.

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

16 “(I) With respect to selected  
17 items and services (as determined ap-  
18 propriate by the Secretary) for which  
19 payment is made under this title and  
20 that are furnished to individuals, who  
21 are patients of a MIPS eligible profes-  
22 sional, by another supplier or provider  
23 of services during the most recent pe-  
24 riod for which data are available (such  
25 as the most recent three-month pe-

1                   riod), such as the name of such pro-  
2                   viders furnishing such items and serv-  
3                   ices to such patients during such pe-  
4                   riod, the types of such items and serv-  
5                   ices so furnished, and the dates such  
6                   items and services were so furnished.

7                   “(II) Historical data, such as  
8                   averages and other measures of the  
9                   distribution if appropriate, of the  
10                  total, and components of, allowed  
11                  charges (and other figures as deter-  
12                  mined appropriate by the Secretary).

13               “(13) REVIEW.—

14               “(A) TARGETED REVIEW.—The Secretary  
15               shall establish a process under which a MIPS  
16               eligible professional may seek an informal re-  
17               view of the calculation of the MIPS adjustment  
18               factor applicable to such eligible professional  
19               under this subsection for a year. The results of  
20               a review conducted pursuant to the previous  
21               sentence shall not be taken into account for  
22               purposes of paragraph (6) with respect to a  
23               year (other than with respect to the calculation  
24               of such eligible professional’s MIPS adjustment  
25               factor for such year or additional MIPS adjust-

1           ment factor for such year) after the factors de-  
2           termined in subparagraph (A) and subpara-  
3           graph (C) of such paragraph have been deter-  
4           mined for such year.

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

9           “(i) The methodology used to deter-  
10          mine the amount of the MIPS adjustment  
11          factor under paragraph (6)(A) and the  
12          amount of the additional MIPS adjustment  
13          factor under paragraph (6)(C)(i) and the  
14          determination of such amounts.

15          “(ii) The establishment of the per-  
16          formance standards under paragraph (3)  
17          and the performance period under para-  
18          graph (4).

19          “(iii) The identification of measures  
20          and activities specified under paragraph  
21          (2)(B) and information made public or  
22          posted on the Physician Compare Internet  
23          website of the Centers for Medicare &  
24          Medicaid Services under paragraph (9).

1 “(iv) The methodology developed  
2 under paragraph (5) that is used to cal-  
3 culate performance scores and the calcula-  
4 tion of such scores, including the weighting  
5 of measures and activities under such  
6 methodology.”.

7 (2) GAO REPORTS.—

8 (A) EVALUATION OF ELIGIBLE PROFES-  
9 SIONAL MIPS.—Not later than October 1, 2019,  
10 and October 1, 2022, the Comptroller General  
11 of the United States shall submit to Congress  
12 a report evaluating the eligible professional  
13 Merit-based Incentive Payment System under  
14 subsection (q) of section 1848 of the Social Se-  
15 curity Act (42 U.S.C. 1395w-4), as added by  
16 paragraph (1). Such report shall—

17 (i) examine the distribution of the  
18 composite performance scores and MIPS  
19 adjustment factors (and additional MIPS  
20 adjustment factors) for MIPS eligible pro-  
21 fessionals (as defined in subsection  
22 (q)(1)(c) of such section) under such pro-  
23 gram, and patterns relating to such scores  
24 and adjustment factors, including based on

1 type of provider, practice size, geographic  
2 location, and patient mix;

3 (ii) provide recommendations for im-  
4 proving such program;

5 (iii) evaluate the impact of technical  
6 assistance funding under section  
7 1848(q)(11) of the Social Security Act, as  
8 added by paragraph (1), on the ability of  
9 professionals to improve within such pro-  
10 gram or successfully transition to an alter-  
11 native payment model (as defined in sec-  
12 tion 1833(z)(3) of the Social Security Act,  
13 as added by subsection (e)), with priority  
14 for such evaluation given to practices lo-  
15 cated in rural areas, health professional  
16 shortage areas (as designated in section  
17 332(a)(1)(a) of the Public Health Service  
18 Act), and medically underserved areas; and

19 (iv) provide recommendations for opti-  
20 mizing the use of such technical assistance  
21 funds.

22 (B) STUDY TO EXAMINE ALIGNMENT OF  
23 QUALITY MEASURES USED IN PUBLIC AND PRI-  
24 VATE PROGRAMS.—



1 (i) IN GENERAL.—Not later than 18  
2 months after the date of the enactment of  
3 this Act, the Comptroller General of the  
4 United States shall submit to Congress a  
5 report that—

6 (I) compares the similarities and  
7 differences in the use of quality meas-  
8 ures under the original Medicare fee-  
9 for-service program under parts A and  
10 B of title XVIII of the Social Security  
11 Act, the Medicare Advantage program  
12 under part C of such title, selected  
13 State Medicaid programs under title  
14 XIX of such Act, and private payer  
15 arrangements; and

16 (II) makes recommendations on  
17 how to reduce the administrative bur-  
18 den involved in applying such quality  
19 measures.

20 (ii) REQUIREMENTS.—The report  
21 under clause (i) shall—

22 (I) consider those measures ap-  
23 plicable to individuals entitled to, or  
24 enrolled for, benefits under such part

1 A, or enrolled under such part B and  
2 individuals under the age of 65; and

3 (II) focus on those measures that  
4 comprise the most significant compo-  
5 nent of the quality performance cat-  
6 egory of the eligible professional  
7 MIPS incentive program under sub-  
8 section (q) of section 1848 of the So-  
9 cial Security Act (42 U.S.C. 1395w-  
10 4), as added by paragraph (1).

11 (C) STUDY ON ROLE OF INDEPENDENT  
12 RISK MANAGERS.—Not later than January 1,  
13 2016, the Comptroller General of the United  
14 States shall submit to Congress a report exam-  
15 ining whether entities that pool financial risk  
16 for physician practices, such as independent  
17 risk managers, can play a role in supporting  
18 physician practices, particularly small physician  
19 practices, in assuming financial risk for the  
20 treatment of patients. Such report shall exam-  
21 ine barriers that small physician practices cur-  
22 rently face in assuming financial risk for treat-  
23 ing patients, the types of risk management enti-  
24 ties that could assist physician practices in par-  
25 ticipating in two-sided risk payment models,

1 and how such entities could assist with risk  
2 management and with quality improvement ac-  
3 tivities. Such report shall also include an anal-  
4 ysis of any existing legal barriers to such ar-  
5 rangements.

6 (D) STUDY TO EXAMINE RURAL AND  
7 HEALTH PROFESSIONAL SHORTAGE AREA AL-  
8 TERNATIVE PAYMENT MODELS.—Not later than  
9 October 1, 2020, and October 1, 2022, the  
10 Comptroller General of the United States shall  
11 submit to Congress a report that examines the  
12 transition of professionals in rural areas, health  
13 professional shortage areas (as designated in  
14 section 332(a)(1)(A) of the Public Health Serv-  
15 ice Act), or medically underserved areas to an  
16 alternative payment model (as defined in sec-  
17 tion 1833(z)(3) of the Social Security Act, as  
18 added by subsection (e)). Such report shall  
19 make recommendations for removing adminis-  
20 trative barriers to practices, including small  
21 practices consisting of 15 or fewer profes-  
22 sionals, in rural areas, health professional  
23 shortage areas, and medically underserved areas  
24 to participation in such models.

1           (3) FUNDING FOR IMPLEMENTATION.—For  
 2           purposes of implementing the provisions of and the  
 3           amendments made by this section, the Secretary of  
 4           Health and Human Services shall provide for the  
 5           transfer of \$80,000,000 from the Supplementary  
 6           Medical Insurance Trust Fund established under  
 7           section 1841 of the Social Security Act (42 U.S.C.  
 8           1395t) to the Centers for Medicare & Medicaid Pro-  
 9           gram Management Account for each of the fiscal  
 10          years 2014 through 2018. Amounts transferred  
 11          under this paragraph shall be available until ex-  
 12          pended.

13          (d) IMPROVING QUALITY REPORTING FOR COM-  
 14          POSITE SCORES.—

15               (1) CHANGES FOR GROUP REPORTING OP-  
 16               TION.—

17                       (A)               IN               GENERAL.—Section  
 18               1848(m)(3)(C)(ii) of the Social Security Act  
 19               (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended  
 20               by inserting “and, for 2015 and subsequent  
 21               years, may provide” after “shall provide”.

22                       (B) CLARIFICATION OF QUALIFIED CLIN-  
 23               ICAL DATA REGISTRY REPORTING TO GROUP  
 24               PRACTICES.—Section 1848(m)(3)(D) of the So-  
 25               cial Security Act (42 U.S.C. 1395w–

1           4(m)(3)(D)) is amended by inserting “and, for  
2           2015 and subsequent years, subparagraph (A)  
3           or (C)” after “subparagraph (A)”.

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

9                   (A) by striking “and subsequent years”  
10                  and inserting “through reporting periods occur-  
11                  ring in 2014”; and

12                  (B) by inserting “and, for reporting peri-  
13                  ods occurring in 2015 and subsequent years,  
14                  the Secretary may establish” following “shall  
15                  establish”.

16           (3) PHYSICIAN FEEDBACK PROGRAM REPORTS  
17           SUCCEEDED BY REPORTS UNDER MIPS.—Section  
18           1848(n) of the Social Security Act (42 U.S.C.  
19           1395w–4(n)) is amended by adding at the end the  
20           following new paragraph:

21                   “(11) REPORTS ENDING WITH 2016.—Reports  
22                  under the Program shall not be provided after De-  
23                  cember 31, 2016. See subsection (q)(12) for reports  
24                  under the eligible professionals Merit-based Incentive  
25                  Payment System.”.

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

8           (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

9           (1) INCREASING TRANSPARENCY OF PHYSICIAN  
 10          FOCUSED PAYMENT MODELS.—Section 1868 of the  
 11          Social Security Act (42 U.S.C. 1395ee) is amended  
 12          by adding at the end the following new subsection:

13          “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

14               “(1) TECHNICAL ADVISORY COMMITTEE.—

15                   “(A) ESTABLISHMENT.—There is estab-  
 16                   lished an ad hoc committee to be known as the  
 17                   ‘Payment Model Technical Advisory Committee’  
 18                   (referred to in this subsection as the ‘Com-  
 19                   mittee’).

20                   “(B) MEMBERSHIP.—

21                       “(i) NUMBER AND APPOINTMENT.—

22                       The Committee shall be composed of 11  
 23                       members appointed by the Comptroller  
 24                       General of the United States.

1           “(ii) QUALIFICATIONS.—The member-  
2           ship of the Committee shall include indi-  
3           viduals with national recognition for their  
4           expertise in payment models and related  
5           delivery of care. No more than 5 members  
6           of the Committee shall be providers of  
7           services or suppliers, or representatives of  
8           providers of services or suppliers.

9           “(iii) PROHIBITION ON FEDERAL EM-  
10          PLOYMENT.—A member of the Committee  
11          shall not be an employee of the Federal  
12          Government.

13          “(iv) ETHICS DISCLOSURE.—The  
14          Comptroller General shall establish a sys-  
15          tem for public disclosure by members of  
16          the Committee of financial and other po-  
17          tential conflicts of interest relating to such  
18          members. Members of the Committee shall  
19          be treated as employees of Congress for  
20          purposes of applying title I of the Ethics  
21          in Government Act of 1978 (Public Law  
22          95–521).

23          “(v) DATE OF INITIAL APPOINT-  
24          MENTS.—The initial appointments of mem-  
25          bers of the Committee shall be made by

1 not later than 180 days after the date of  
2 enactment of this subsection.

3 “(C) TERM; VACANCIES.—

4 “(i) TERM.—The terms of members of  
5 the Committee shall be for 3 years except  
6 that the Comptroller General shall des-  
7 ignate staggered terms for the members  
8 first appointed.

9 “(ii) VACANCIES.—Any member ap-  
10 pointed to fill a vacancy occurring before  
11 the expiration of the term for which the  
12 member’s predecessor was appointed shall  
13 be appointed only for the remainder of that  
14 term. A member may serve after the expi-  
15 ration of that member’s term until a suc-  
16 cessor has taken office. A vacancy in the  
17 Committee shall be filled in the manner in  
18 which the original appointment was made.

19 “(D) DUTIES.—The Committee shall meet,  
20 as needed, to provide comments and rec-  
21 ommendations to the Secretary, as described in  
22 paragraph (2)(C), on physician-focused pay-  
23 ment models.

24 “(E) COMPENSATION OF MEMBERS.—



1 “(i) IN GENERAL.—Except as pro-  
 2 vided in clause (ii), a member of the Com-  
 3 mittee shall serve without compensation.

4 “(ii) TRAVEL EXPENSES.—A member  
 5 of the Committee shall be allowed travel  
 6 expenses, including per diem in lieu of sub-  
 7 sistence, at rates authorized for an em-  
 8 ployee of an agency under subchapter I of  
 9 chapter 57 of title 5, United States Code,  
 10 while away from the home or regular place  
 11 of business of the member in the perform-  
 12 ance of the duties of the Committee.

13 “(F) OPERATIONAL AND TECHNICAL SUP-  
 14 PORT.—

15 “(i) IN GENERAL.—The Assistant  
 16 Secretary for Planning and Evaluation  
 17 shall provide technical and operational sup-  
 18 port for the Committee, which may be by  
 19 use of a contractor. The Office of the Ac-  
 20 tuary of the Centers for Medicare & Med-  
 21 icaid Services shall provide to the Com-  
 22 mittee actuarial assistance as needed.

23 “(ii) FUNDING.—The Secretary shall  
 24 provide for the transfer, from the Federal  
 25 Supplementary Medical Insurance Trust

1 Fund under section 1841, such amounts as  
 2 are necessary to carry out clause (i) (not  
 3 to exceed \$5,000,000) for fiscal year 2014  
 4 and each subsequent fiscal year. Any  
 5 amounts transferred under the preceding  
 6 sentence for a fiscal year shall remain  
 7 available until expended.

8 “(G) APPLICATION.—Section 14 of the  
 9 Federal Advisory Committee Act (5 U.S.C.  
 10 App.) shall not apply to the Committee.

11 “(2) CRITERIA AND PROCESS FOR SUBMISSION  
 12 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT  
 13 MODELS.—

14 “(A) CRITERIA FOR ASSESSING PHYSICIAN-  
 15 FOCUSED PAYMENT MODELS.—

16 “(i) RULEMAKING.—Not later than  
 17 November 1, 2015, the Secretary shall,  
 18 through notice and comment rulemaking,  
 19 following a request for information, estab-  
 20 lish criteria for physician-focused payment  
 21 models, including models for specialist phy-  
 22 sicians, that could be used by the Com-  
 23 mittee for making comments and rec-  
 24 ommendations pursuant to paragraph  
 25 (1)(D).

1                   “(ii) MEDPAC SUBMISSION OF COM-  
2                   MENTS.—During the comment period for  
3                   the proposed rule described in clause (i),  
4                   the Medicare Payment Advisory Commis-  
5                   sion may submit comments to the Sec-  
6                   retary on the proposed criteria under such  
7                   clause.

8                   “(iii) UPDATING.—The Secretary may  
9                   update the criteria established under this  
10                  subparagraph through rulemaking.

11                  “(B) STAKEHOLDER SUBMISSION OF PHY-  
12                  SICIAN FOCUSED PAYMENT MODELS.—On an  
13                  ongoing basis, individuals and stakeholder enti-  
14                  ties may submit to the Committee proposals for  
15                  physician-focused payment models that such in-  
16                  dividuals and entities believe meet the criteria  
17                  described in subparagraph (A).

18                  “(C) TAC REVIEW OF MODELS SUB-  
19                  MITTED.—The Committee shall, on a periodic  
20                  basis, review models submitted under subpara-  
21                  graph (B), prepare comments and recommenda-  
22                  tions regarding whether such models meet the  
23                  criteria described in subparagraph (A), and  
24                  submit such comments and recommendations to  
25                  the Secretary.

1                   “(D) SECRETARY REVIEW AND RE-  
 2                   SPONSE.—The Secretary shall review the com-  
 3                   ments and recommendations submitted by the  
 4                   Committee under subparagraph (C) and post a  
 5                   detailed response to such comments and rec-  
 6                   ommendations on the Internet Website of the  
 7                   Centers for Medicare & Medicaid Services.

8                   “(3) RULE OF CONSTRUCTION.—Nothing in  
 9                   this subsection shall be construed to impact the de-  
 10                  velopment or testing of models under this title or ti-  
 11                  tles XI, XIX, or XXI.”.

12                  (2) INCENTIVE PAYMENTS FOR PARTICIPATION  
 13                  IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—  
 14                  Section 1833 of the Social Security Act (42 U.S.C.  
 15                  1395l) is amended by adding at the end the fol-  
 16                  lowing new subsection:

17                  “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN  
 18                  ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

19                         “(1) PAYMENT INCENTIVE.—

20                                 “(A) IN GENERAL.—In the case of covered  
 21                                 professional services furnished by an eligible  
 22                                 professional during a year that is in the period  
 23                                 beginning with 2018 and ending with 2023 and  
 24                                 for which the professional is a qualifying APM  
 25                                 participant, in addition to the amount of pay-

1           ment that would otherwise be made for such  
2           covered professional services under this part for  
3           such year, there also shall be paid to such pro-  
4           fessional an amount equal to 5 percent of the  
5           payment amount for the covered professional  
6           services under this part for the preceding year.  
7           For purposes of the previous sentence, the pay-  
8           ment amount for the preceding year may be an  
9           estimation for the full preceding year based on  
10          a period of such preceding year that is less than  
11          the full year. The Secretary shall establish poli-  
12          cies to implement this subparagraph in cases  
13          where payment for covered professional services  
14          furnished by a qualifying APM participant in  
15          an alternative payment model is made to an en-  
16          tity participating in the alternative payment  
17          model rather than directly to the qualifying  
18          APM participant.

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

22               “(C) TREATMENT OF PAYMENT INCEN-  
23               TIVE.—Payments under this subsection shall  
24               not be taken into account for purposes of deter-  
25               mining actual expenditures under an alternative

1 payment model and for purposes of determining  
2 or rebasing any benchmarks used under the al-  
3 ternative payment model.

4 “(D) COORDINATION.—The amount of the  
5 additional payment for an item or service under  
6 this subsection or subsection (m) shall be deter-  
7 mined without regard to any additional pay-  
8 ment for the item or service under subsection  
9 (m) and this subsection, respectively. The  
10 amount of the additional payment for an item  
11 or service under this subsection or subsection  
12 (x) shall be determined without regard to any  
13 additional payment for the item or service  
14 under subsection (x) and this subsection, re-  
15 spectively. The amount of the additional pay-  
16 ment for an item or service under this sub-  
17 section or subsection (y) shall be determined  
18 without regard to any additional payment for  
19 the item or service under subsection (y) and  
20 this subsection, respectively.

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

24 “(A) 2018 AND 2019.—With respect to  
25 2018 and 2019, an eligible professional for

1       whom the Secretary determines that at least 25  
2       percent of payments under this part for covered  
3       professional services furnished by such profes-  
4       sional during the most recent period for which  
5       data are available (which may be less than a  
6       year) were attributable to such services fur-  
7       nished under this part through an entity that  
8       participates in an eligible alternative payment  
9       model with respect to such services.

10       “(B) 2020 AND 2021.—With respect to  
11       2020 and 2021, an eligible professional de-  
12       scribed in either of the following clauses:

13       “(i) MEDICARE REVENUE THRESHOLD  
14       OPTION.—An eligible professional for  
15       whom the Secretary determines that at  
16       least 50 percent of payments under this  
17       part for covered professional services fur-  
18       nished by such professional during the  
19       most recent period for which data are  
20       available (which may be less than a year)  
21       were attributable to such services furnished  
22       under this part through an entity that par-  
23       ticipates in an eligible alternative payment  
24       model with respect to such services.

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

4 “(I) for whom the Secretary de-  
5 termines, with respect to items and  
6 services furnished by such professional  
7 during the most recent period for  
8 which data are available (which may  
9 be less than a year), that at least 50  
10 percent of the sum of—

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

13 “(bb) all other payments, re-  
14 gardless of payer (other than  
15 payments made by the Secretary  
16 of Defense or the Secretary of  
17 Veterans Affairs under chapter  
18 55 of title 10, United States  
19 Code, or title 38, United States  
20 Code, or any other provision of  
21 law, and other than payments  
22 made under title XIX in a State  
23 in which no medical home or al-  
24 ternative payment model is avail-



1                   able under the State program  
2                   under that title),  
3                   meet the requirement described in  
4                   clause (iii)(I) with respect to pay-  
5                   ments described in item (aa) and meet  
6                   the requirement described in clause  
7                   (iii)(II) with respect to payments de-  
8                   scribed in item (bb);

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

21                  “(III) who provides to the Sec-  
22                  retary such information as is nec-  
23                  essary for the Secretary to make a de-  
24                  termination under subclause (I), with  
25                  respect to such professional.

1 “(iii) REQUIREMENT.—For purposes  
2 of clause (ii)(I)—

3 “(I) the requirement described in  
4 this subclause, with respect to pay-  
5 ments described in item (aa) of such  
6 clause, is that such payments are  
7 made under an eligible alternative  
8 payment model; and

9 “(II) the requirement described  
10 in this subclause, with respect to pay-  
11 ments described in item (bb) of such  
12 clause, is that such payments are  
13 made under an arrangement in  
14 which—

15 “(aa) quality measures com-  
16 parable to measures under the  
17 performance category described  
18 in section 1848(q)(2)(B)(i) apply;

19 “(bb) certified EHR tech-  
20 nology is used; and

21 “(cc) the eligible profes-  
22 sional (AA) bears more than  
23 nominal financial risk if actual  
24 aggregate expenditures exceeds  
25 expected aggregate expenditures;

1 or (BB) is a medical home (with  
2 respect to beneficiaries under  
3 title XIX) that meets criteria  
4 comparable to medical homes ex-  
5 panded under section 1115A(c).

6 “(C) BEGINNING IN 2022.—With respect to  
7 2022 and each subsequent year, an eligible pro-  
8 fessional described in either of the following  
9 clauses:

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

22 “(ii) COMBINATION ALL-PAYER AND  
23 MEDICARE REVENUE THRESHOLD OP-  
24 TION.—An eligible professional—

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

8 “(aa) payments described in  
9 clause (i); and

10 “(bb) all other payments, re-  
11 gardless of payer (other than  
12 payments made by the Secretary  
13 of Defense or the Secretary of  
14 Veterans Affairs under chapter  
15 55 of title 10, United States  
16 Code, or title 38, United States  
17 Code, or any other provision of  
18 law, and other than payments  
19 made under title XIX in a State  
20 in which no medical home or al-  
21 ternative payment model is avail-  
22 able under the State program  
23 under that title),  
24 meet the requirement described in  
25 clause (iii)(I) with respect to pay-

1           ments described in item (aa) and meet  
2           the requirement described in clause  
3           (iii)(II) with respect to payments de-  
4           scribed in item (bb);

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

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

22          “(iii) REQUIREMENT.—For purposes  
23          of clause (ii)(I)—

24                 “(I) the requirement described in  
25                 this subclause, with respect to pay-

1           ments described in item (aa) of such  
2           clause, is that such payments are  
3           made under an eligible alternative  
4           payment model; and

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

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

15           “(bb) certified EHR tech-  
16           nology is used; and

17           “(cc) the eligible profes-  
18           sional (AA) bears more than  
19           nominal financial risk if actual  
20           aggregate expenditures exceeds  
21           expected aggregate expenditures;  
22           or (BB) is a medical home (with  
23           respect to beneficiaries under  
24           title XIX) that meets criteria

1 comparable to medical homes ex-  
2 panded under section 1115A(c).

3 “(3) ADDITIONAL DEFINITIONS.—In this sub-  
4 section:

5 “(A) COVERED PROFESSIONAL SERV-  
6 ICES.—The term ‘covered professional services’  
7 has the meaning given that term in section  
8 1848(k)(3)(A).

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

12 “(C) ALTERNATIVE PAYMENT MODEL  
13 (APM).—The term ‘alternative payment model’  
14 means any of the following:

15 “(i) A model under section 1115A  
16 (other than a health care innovation  
17 award).

18 “(ii) The shared savings program  
19 under section 1899.

20 “(iii) A demonstration under section  
21 1866C.

22 “(iv) A demonstration required by  
23 Federal law.

24 “(D) ELIGIBLE ALTERNATIVE PAYMENT  
25 MODEL (APM).—

1 “(i) IN GENERAL.—The term ‘eligible  
 2 alternative payment model’ means, with re-  
 3 spect to a year, an alternative payment  
 4 model—

5 “(I) that requires use of certified  
 6 EHR technology (as defined in sub-  
 7 section (o)(4));

8 “(II) that provides for payment  
 9 for covered professional services based  
 10 on quality measures comparable to  
 11 measures under the performance cat-  
 12 egory described in section  
 13 1848(q)(2)(B)(i); and

14 “(III) that satisfies the require-  
 15 ment described in clause (ii).

16 “(ii) ADDITIONAL REQUIREMENT.—  
 17 For purposes of clause (i)(III), the require-  
 18 ment described in this clause, with respect  
 19 to a year and an alternative payment  
 20 model, is that the alternative payment  
 21 model—

22 “(I) is one in which one or more  
 23 entities bear financial risk for mone-  
 24 tary losses under such model that are  
 25 in excess of a nominal amount; or



1 “(II) is a medical home expanded  
2 under section 1115A(c).

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

6 “(A) The determination that an eligible  
7 professional is a qualifying APM participant  
8 under paragraph (2) and the determination  
9 that an alternative payment model is an eligible  
10 alternative payment model under paragraph  
11 (3)(D).

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

16 (3) COORDINATION CONFORMING AMEND-  
17 MENTS.—Section 1833 of the Social Security Act  
18 (42 U.S.C. 1395l) is further amended—

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

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

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

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

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

“(xxii) Focusing on practices of 15 or fewer professionals.

“(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hos-

1           pital readmissions rates, and other relevant  
2           and appropriate clinical measures.

3           “(xxiv) Focusing primarily on title  
4           XIX, working in conjunction with the Cen-  
5           ter for Medicaid and CHIP Services.”; and  
6           (B) in subparagraph (C)(viii), by striking  
7           “other public sector or private sector payers”  
8           and inserting “other public sector payers, pri-  
9           vate sector payers, or Statewide payment mod-  
10          els”.

11          (5) CONSTRUCTION REGARDING TELEHEALTH  
12          SERVICES.—Nothing in the provisions of, or amend-  
13          ments made by, this Act shall be construed as pre-  
14          cluding an alternative payment model or a qualifying  
15          APM participant (as those terms are defined in sec-  
16          tion 1833(z) of the Social Security Act, as added by  
17          paragraph (1)) from furnishing a telehealth service  
18          for which payment is not made under section  
19          1834(m) of the Social Security Act (42 U.S.C.  
20          1395m(m)).

21          (6) INTEGRATING MEDICARE ADVANTAGE AL-  
22          TERNATIVE PAYMENT MODELS.—Not later than July  
23          1, 2015, the Secretary of Health and Human Serv-  
24          ices shall submit to Congress a study that examines  
25          the feasibility of integrating alternative payment

1 models in the Medicare Advantage payment system.  
 2 The study shall include the feasibility of including a  
 3 value-based modifier and whether such modifier  
 4 should be budget neutral.

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

8 (A) STUDY.—The Secretary of Health and  
 9 Human Services, in consultation with the In-  
 10 spector General of the Department of Health  
 11 and Human Services, shall conduct a study  
 12 that—

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

20 (ii) identifies aspects of such alter-  
 21 native payment models that are vulnerable  
 22 to fraudulent activity; and

23 (iii) examines the implications of waiv-  
 24 ers to such laws granted in support of such  
 25 alternative payment models, including

1 under any potential expansion of such  
2 models.

3 (B) REPORT.—Not later than 2 years after  
4 the date of the enactment of this Act, the Sec-  
5 retary shall submit to Congress a report con-  
6 taining the results of the study conducted under  
7 subparagraph (A). Such report shall include  
8 recommendations for actions to be taken to re-  
9 duce the vulnerability of such alternative pay-  
10 ment models to fraudulent activity. Such report  
11 also shall include, as appropriate, recommenda-  
12 tions of the Inspector General for changes in  
13 Federal fraud prevention laws to reduce such  
14 vulnerability.

15 (f) IMPROVING PAYMENT ACCURACY.—

16 (1) STUDIES AND REPORTS OF EFFECT OF CER-  
17 TAIN INFORMATION ON QUALITY AND RESOURCE  
18 USE.—

19 (A) STUDY USING EXISTING MEDICARE  
20 DATA.—

21 (i) STUDY.—The Secretary of Health  
22 and Human Services (in this subsection re-  
23 ferred to as the “Secretary”) shall conduct  
24 a study that examines the effect of individ-  
25 uals’ socioeconomic status on quality and

1 resource use outcome measures for individ-  
2 uals under the Medicare program (such as  
3 to recognize that less healthy individuals  
4 may require more intensive interventions).  
5 The study shall use information collected  
6 on such individuals in carrying out such  
7 program, such as urban and rural location,  
8 eligibility for Medicaid (recognizing and ac-  
9 counting for varying Medicaid eligibility  
10 across States), and eligibility for benefits  
11 under the supplemental security income  
12 (SSI) program. The Secretary shall carry  
13 out this paragraph acting through the As-  
14 sistant Secretary for Planning and Evalua-  
15 tion.

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

21 (B) STUDY USING OTHER DATA.—

22 (i) STUDY.—The Secretary shall con-  
23 duct a study that examines the impact of  
24 risk factors, such as those described in sec-  
25 tion 1848(p)(3) of the Social Security Act

1 (42 U.S.C. 1395w-4(p)(3)), race, health  
2 literacy, limited English proficiency (LEP),  
3 and patient activation, on quality and re-  
4 source use outcome measures under the  
5 Medicare program (such as to recognize  
6 that less healthy individuals may require  
7 more intensive interventions). In con-  
8 ducting such study the Secretary may use  
9 existing Federal data and collect such ad-  
10 ditional data as may be necessary to com-  
11 plete the study.

12 (ii) REPORT.—Not later than 5 years  
13 after the date of the enactment of this Act,  
14 the Secretary shall submit to Congress a  
15 report on the study conducted under clause  
16 (i).

17 (C) EXAMINATION OF DATA IN CON-  
18 DUCTING STUDIES.—In conducting the studies  
19 under subparagraphs (A) and (B), the Sec-  
20 retary shall examine what non-Medicare data  
21 sets, such as data from the American Commu-  
22 nity Survey (ACS), can be useful in conducting  
23 the types of studies under such paragraphs and  
24 how such data sets that are identified as useful  
25 can be coordinated with Medicare administra-

1           tive data in order to improve the overall data  
 2           set available to do such studies and for the ad-  
 3           ministration of the Medicare program.

4           (D) RECOMMENDATIONS TO ACCOUNT FOR  
 5           INFORMATION IN PAYMENT ADJUSTMENT  
 6           MECHANISMS.—If the studies conducted under  
 7           subparagraphs (A) and (B) find a relationship  
 8           between the factors examined in the studies and  
 9           quality and resource use outcome measures,  
 10          then the Secretary shall also provide rec-  
 11          ommendations for how the Centers for Medicare  
 12          & Medicaid Services should—

13               (i) obtain access to the necessary data  
 14               (if such data is not already being collected)  
 15               on such factors, including recommenda-  
 16               tions on how to address barriers to the  
 17               Centers in accessing such data; and

18               (ii) account for such factors in deter-  
 19               mining payment adjustments based on  
 20               quality and resource use outcome measures  
 21               under the eligible professional Merit-based  
 22               Incentive Payment System under section  
 23               1848(q) of the Social Security Act (42  
 24               U.S.C. 1395w-4(q)) and, as the Secretary



determines appropriate, other similar provisions of title XVIII of such Act.

(E) FUNDING.—There are hereby appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act to the Secretary to carry out this paragraph \$6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) HIERARCHICAL CONDITION CATEGORY (HCC) IMPROVEMENT.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1), the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate, estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into provisions of title XVIII of the Social Security Act that are similar to the eligible professional Merit-based Incentive Payment System under section 1848(q) of such Act.

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

3 (i) IN GENERAL.—Taking into ac-  
4 count the studies conducted and rec-  
5 ommendations made in reports under para-  
6 graph (1) and other information as appro-  
7 priate, the Secretary shall, as the Sec-  
8 retary determines appropriate, account for  
9 identified factors with an effect on quality  
10 and resource use outcome measures when  
11 determining payment adjustment mecha-  
12 nisms under provisions of title XVIII of  
13 the Social Security Act that are similar to  
14 the eligible professional Merit-based Incen-  
15 tive Payment System under section  
16 1848(q) of such Act.

17 (ii) ACCESSING DATA.—The Secretary  
18 shall collect or otherwise obtain access to  
19 the data necessary to carry out this para-  
20 graph through existing and new data  
21 sources.

22 (iii) PERIODIC ANALYSES.—The Sec-  
23 retary shall carry out periodic analyses, at  
24 least every 3 years, based on the factors

1 referred to in clause (i) so as to monitor  
2 changes in possible relationships.

3 (C) FUNDING.—There are hereby appro-  
4 priated from the Federal Supplementary Med-  
5 ical Insurance Trust Fund under section 1841  
6 of the Social Security Act to the Secretary to  
7 carry out this paragraph and the application of  
8 this paragraph to the Merit-based Incentive  
9 Payment System under section 1848(q) of such  
10 Act \$10,000,000, to remain available until ex-  
11 pended.

12 (3) STRATEGIC PLAN FOR ACCESSING RACE  
13 AND ETHNICITY DATA.—Not later than 18 months  
14 after the date of the enactment of this Act, the Sec-  
15 retary shall develop and report to Congress on a  
16 strategic plan for collecting or otherwise accessing  
17 data on race and ethnicity for purposes of carrying  
18 out the eligible professional Merit-based Incentive  
19 Payment System under section 1848(q) of the Social  
20 Security Act and, as the Secretary determines ap-  
21 propriate, other similar provisions of title XVIII of  
22 such Act.

23 (g) COLLABORATING WITH THE PHYSICIAN, PRACTI-  
24 TIONER, AND OTHER STAKEHOLDER COMMUNITIES TO  
25 IMPROVE RESOURCE USE MEASUREMENT.—Section 1848

1 of the Social Security Act (42 U.S.C. 1395w-4), as  
 2 amended by subsection (c), is further amended by adding  
 3 at the end the following new subsection:

4 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-  
 5 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO  
 6 IMPROVE RESOURCE USE MEASUREMENT.—

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

16 “(2) DEVELOPMENT OF CARE EPISODE AND PA-  
 17 TIENT CONDITION GROUPS AND CLASSIFICATION  
 18 CODES.—

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

24 “(B) PUBLIC AVAILABILITY OF EXISTING  
 25 EFFORTS TO DESIGN AN EPISODE GROUPER.—

1 Not later than 120 days after the date of the  
 2 enactment of this subsection, the Secretary  
 3 shall post on the Internet website of the Cen-  
 4 ters for Medicare & Medicaid Services a list of  
 5 the episode groups developed pursuant to sub-  
 6 section (n)(9)(A) and related descriptive infor-  
 7 mation.

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

18 “(i) care episode groups; and

19 “(ii) patient condition groups.

20 “(D) DEVELOPMENT OF PROPOSED CLAS-  
 21 SIFICATION CODES.—

22 “(i) IN GENERAL.—Taking into ac-  
 23 count the information described in sub-  
 24 paragraph (B) and the information re-

ceived under subparagraph (C), the Secretary shall—

“(I) establish care episode groups and patient condition groups, which account for a target of an estimated  $\frac{2}{3}$  of expenditures under parts A and B; and

“(II) assign codes to such groups.

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

“(I) the patient’s clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and

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

“(iii) PATIENT CONDITION GROUPS.—  
In establishing the patient condition

groups under clause (i), the Secretary shall  
take into account—

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

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

“(E) DRAFT CARE EPISODE AND PATIENT  
CONDITION GROUPS AND CLASSIFICATION  
CODES.—Not later than 180 days after the end  
of the comment period described in subpara-  
graph (C), the Secretary shall post on the  
Internet website of the Centers for Medicare &  
Medicaid Services a draft list of the care epi-  
sode and patient condition codes established

1 under subparagraph (D) (and the criteria and  
2 characteristics assigned to such code).

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

18 “(G) OPERATIONAL LIST OF CARE EPI-  
19 SODE AND PATIENT CONDITION GROUPS AND  
20 CODES.—Not later than 180 days after the end  
21 of the comment period described in subpara-  
22 graph (F), taking into account the comments  
23 received under such subparagraph, the Sec-  
24 retary shall post on the Internet website of the  
25 Centers for Medicare & Medicaid Services an



1 operational list of care episode and patient con-  
2 dition codes (and the criteria and characteris-  
3 tics assigned to such code).

4 “(H) SUBSEQUENT REVISIONS.—Not later  
5 than November 1 of each year (beginning with  
6 2017), the Secretary shall, through rulemaking,  
7 make revisions to the operational lists of care  
8 episode and patient condition codes as the Sec-  
9 retary determines may be appropriate. Such re-  
10 visions may be based on experience, new infor-  
11 mation developed pursuant to subsection  
12 (n)(9)(A), and input from the physician spe-  
13 cialty societies, applicable practitioner organiza-  
14 tions, and other stakeholders, including rep-  
15 resentatives of individuals entitled to benefits  
16 under part A or enrolled under this part.

17 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-  
18 CIANS OR PRACTITIONERS.—

19 “(A) IN GENERAL.—In order to facilitate  
20 the attribution of patients and episodes (in  
21 whole or in part) to one or more physicians or  
22 applicable practitioners furnishing items and  
23 services, the Secretary shall undertake the steps  
24 described in the succeeding provisions of this  
25 paragraph.

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

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

“(ii) considers themselves to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

“(iii) furnishes items and services to the patient on a continuing basis during an

1 acute episode of care, but in a supportive  
 2 rather than a lead role;

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

7 “(v) furnishes items and services only  
 8 as ordered by another physician or practi-  
 9 tioner.

10 “(C) DRAFT LIST OF PATIENT RELATION-  
 11 SHIP CATEGORIES AND CODES.—Not later than  
 12 270 days after the date of the enactment of this  
 13 subsection, the Secretary shall post on the  
 14 Internet website of the Centers for Medicare &  
 15 Medicaid Services a draft list of the patient re-  
 16 lationship categories and codes developed under  
 17 subparagraph (B).

18 “(D) STAKEHOLDER INPUT.—The Sec-  
 19 retary shall seek, through the date that is 60  
 20 days after the Secretary posts the list pursuant  
 21 to subparagraph (C), comments from physician  
 22 specialty societies, applicable practitioner orga-  
 23 nizations, and other stakeholders, including rep-  
 24 resentatives of individuals entitled to benefits  
 25 under part A or enrolled under this part, re-

1       garding the patient relationship categories and  
2       codes posted under subparagraph (C). In seek-  
3       ing such comments, the Secretary shall use one  
4       or more mechanisms (other than notice and  
5       comment rulemaking) that may include open  
6       door forums, town hall meetings, or other ap-  
7       propriate mechanisms.

8               “(E) OPERATIONAL LIST OF PATIENT RE-  
9       LATIONSHIP CATEGORIES AND CODES.—Not  
10      later than 180 days after the end of the com-  
11      ment period described in subparagraph (D),  
12      taking into account the comments received  
13      under such subparagraph, the Secretary shall  
14      post on the Internet website of the Centers for  
15      Medicare & Medicaid Services an operational  
16      list of patient relationship categories and codes.

17              “(F) SUBSEQUENT REVISIONS.—Not later  
18      than November 1 of each year (beginning with  
19      2017), the Secretary shall, through rulemaking,  
20      make revisions to the operational list of patient  
21      relationship categories and codes as the Sec-  
22      retary determines appropriate. Such revisions  
23      may be based on experience, new information  
24      developed pursuant to subsection (n)(9)(A), and  
25      input from the physician specialty societies, ap-

1 applicable practitioner organizations, and other  
 2 stakeholders, including representatives of indi-  
 3 viduals entitled to benefits under part A or en-  
 4 rolled under this part.

5 “(4) REPORTING OF INFORMATION FOR RE-  
 6 SOURCE USE MEASUREMENT.—Claims submitted for  
 7 items and services furnished by a physician or appli-  
 8 cable practitioner on or after January 1, 2017, shall,  
 9 as determined appropriate by the Secretary, in-  
 10 clude—

11 “(A) applicable codes established under  
 12 paragraphs (2) and (3); and

13 “(B) the national provider identifier of the  
 14 ordering physician or applicable practitioner (if  
 15 different from the billing physician or applicable  
 16 practitioner).

17 “(5) METHODOLOGY FOR RESOURCE USE ANAL-  
 18 YSIS.—

19 “(A) IN GENERAL.—In order to evaluate  
 20 the resources used to treat patients (with re-  
 21 spect to care episode and patient condition  
 22 groups), the Secretary shall—

23 “(i) use the patient relationship codes  
 24 reported on claims pursuant to paragraph  
 25 (4) to attribute patients (in whole or in

1 part) to one or more physicians and appli-  
2 cable practitioners;

3 “(ii) use the care episode and patient  
4 condition codes reported on claims pursu-  
5 ant to paragraph (4) as a basis to compare  
6 similar patients and care episodes and pa-  
7 tient condition groups; and

8 “(iii) conduct an analysis of resource  
9 use (with respect to care episodes and pa-  
10 tient condition groups of such patients), as  
11 the Secretary determines appropriate.

12 “(B) ANALYSIS OF PATIENTS OF PHYSI-  
13 CIANS AND PRACTITIONERS.—In conducting the  
14 analysis described in subparagraph (A)(iii) with  
15 respect to patients attributed to physicians and  
16 applicable practitioners, the Secretary shall, as  
17 feasible—

18 “(i) use the claims data experience of  
19 such patients by patient condition codes  
20 during a common period, such as 12  
21 months; and

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

24 “(I) in the case of episodes with-  
25 out a hospitalization, during periods

1 of time (such as the number of days)  
2 determined appropriate by the Sec-  
3 retary; and

4 “(II) in the case of episodes with  
5 a hospitalization, during periods of  
6 time (such as the number of days) be-  
7 fore, during, and after the hospitaliza-  
8 tion.

9 “(C) MEASUREMENT OF RESOURCE USE.—

10 In measuring such resource use, the Sec-  
11 retary—

12 “(i) shall use per patient total allowed  
13 charges for all services under part A and  
14 this part (and, if the Secretary determines  
15 appropriate, part D) for the analysis of pa-  
16 tient resource use, by care episode codes  
17 and by patient condition codes; and

18 “(ii) may, as determined appropriate,  
19 use other measures of allowed charges  
20 (such as subtotals for categories of items  
21 and services) and measures of utilization of  
22 items and services (such as frequency of  
23 specific items and services and the ratio of  
24 specific items and services among attrib-  
25 uted patients or episodes).

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

14          “(6) IMPLEMENTATION.—To the extent that  
15          the Secretary contracts with an entity to carry out  
16          any part of the provisions of this subsection, the  
17          Secretary may not contract with an entity or an en-  
18          tity with a subcontract if the entity or subcon-  
19          tracting entity currently makes recommendations to  
20          the Secretary on relative values for services under  
21          the fee schedule for physicians’ services under this  
22          section.

23          “(7) LIMITATION.—There shall be no adminis-  
24          trative or judicial review under section 1869, section  
25          1878, or otherwise of—



1           “(A) care episode and patient condition  
2           groups and codes established under paragraph  
3           (2);

4           “(B) patient relationship categories and  
5           codes established under paragraph (3); and

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

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

12          “(9) DEFINITIONS.—In this section:

13               “(A) PHYSICIAN.—The term ‘physician’  
14               has the meaning given such term in section  
15               1861(r)(1).

16               “(B) APPLICABLE PRACTITIONER.—The  
17               term ‘applicable practitioner’ means—

18                       “(i) a physician assistant, nurse prac-  
19                       titioner, and clinical nurse specialist (as  
20                       such terms are defined in section  
21                       1861(aa)(5)), and a certified registered  
22                       nurse anesthetist (as defined in section  
23                       1861(bb)(2)); and

24                       “(ii) beginning January 1, 2018, such  
25                       other eligible professionals (as defined in

1 subsection (k)(3)(B)) as specified by the  
 2 Secretary.

3 “(10) CLARIFICATION.—The provisions of sec-  
 4 tions 1890(b)(7) and 1890A shall not apply to this  
 5 subsection.”.

6 **SEC. 3. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**  
 7 **OPMENT.**

8 Section 1848 of the Social Security Act (42 U.S.C.  
 9 1395w-4), as amended by subsections (c) and (g) of sec-  
 10 tion 2, is further amended by inserting at the end the fol-  
 11 lowing new subsection:

12 “(s) PRIORITIES AND FUNDING FOR MEASURE DE-  
 13 VELOPMENT.—

14 “(1) PLAN IDENTIFYING MEASURE DEVELOP-  
 15 MENT PRIORITIES AND TIMELINES.—

16 “(A) DRAFT MEASURE DEVELOPMENT  
 17 PLAN.—Not later than January 1, 2015, the  
 18 Secretary shall develop, and post on the Inter-  
 19 net website of the Centers for Medicare & Med-  
 20 icaid Services, a draft plan for the development  
 21 of quality measures for application under the  
 22 applicable provisions (as defined in paragraph  
 23 (5)). Under such plan the Secretary shall—

24 “(i) address how measures used by  
 25 private payers and integrated delivery sys-

1           tems could be incorporated under title  
2           XVIII;

3           “(ii) describe how coordination, to the  
4           extent possible, will occur across organiza-  
5           tions developing such measures; and

6           “(iii) take into account how clinical  
7           best practices and clinical practice guide-  
8           lines should be used in the development of  
9           quality measures.

10          “(B) QUALITY DOMAINS.—For purposes of  
11          this subsection, the term ‘quality domains’  
12          means at least the following domains:

13               “(i) Clinical care.

14               “(ii) Safety.

15               “(iii) Care coordination.

16               “(iv) Patient and caregiver experience.

17               “(v) Population health and preven-  
18          tion.

19          “(C) CONSIDERATION.—In developing the  
20          draft plan under this paragraph, the Secretary  
21          shall consider—

22               “(i) gap analyses conducted by the en-  
23               tity with a contract under section 1890(a)  
24               or other contractors or entities;

1 “(ii) whether measures are applicable  
2 across health care settings;

3 “(iii) clinical practice improvement ac-  
4 tivities submitted under subsection  
5 (q)(2)(C)(iv) for identifying possible areas  
6 for future measure development and identi-  
7 fying existing gaps with respect to such  
8 measures; and

9 “(iv) the quality domains applied  
10 under this subsection.

11 “(D) PRIORITIES.—In developing the draft  
12 plan under this paragraph, the Secretary shall  
13 give priority to the following types of measures:

14 “(i) Outcome measures, including pa-  
15 tient reported outcome and functional sta-  
16 tus measures.

17 “(ii) Patient experience measures.

18 “(iii) Care coordination measures.

19 “(iv) Measures of appropriate use of  
20 services, including measures of over use.

21 “(E) STAKEHOLDER INPUT.—The Sec-  
22 retary shall accept through March 1, 2015,  
23 comments on the draft plan posted under para-  
24 graph (1)(A) from the public, including health

1 care providers, payers, consumers, and other  
2 stakeholders.

3 “(F) FINAL MEASURE DEVELOPMENT  
4 PLAN.—Not later than May 1, 2015, taking  
5 into account the comments received under this  
6 subparagraph, the Secretary shall finalize the  
7 plan and post on the Internet website of the  
8 Centers for Medicare & Medicaid Services an  
9 operational plan for the development of quality  
10 measures for use under the applicable provi-  
11 sions. Such plan shall be updated as appro-  
12 priate.

13 “(2) CONTRACTS AND OTHER ARRANGEMENTS  
14 FOR QUALITY MEASURE DEVELOPMENT.—

15 “(A) IN GENERAL.—The Secretary shall  
16 enter into contracts or other arrangements with  
17 entities for the purpose of developing, improv-  
18 ing, updating, or expanding in accordance with  
19 the plan under paragraph (1) quality measures  
20 for application under the applicable provisions.  
21 Such entities shall include organizations with  
22 quality measure development expertise.

23 “(B) PRIORITIZATION.—

24 “(i) IN GENERAL.—In entering into  
25 contracts or other arrangements under

1           subparagraph (A), the Secretary shall give  
2           priority to the development of the types of  
3           measures described in paragraph (1)(D).

4           “(ii) CONSIDERATION.—In selecting  
5           measures for development under this sub-  
6           section, the Secretary shall consider—

7                   “(I) whether such measures  
8                   would be electronically specified; and

9                   “(II) clinical practice guidelines  
10                  to the extent that such guidelines  
11                  exist.

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

13               “(A) IN GENERAL.—Not later than May 1,  
14               2016, and annually thereafter, the Secretary  
15               shall post on the Internet website of the Cen-  
16               ters for Medicare & Medicaid Services a report  
17               on the progress made in developing quality  
18               measures for application under the applicable  
19               provisions.

20               “(B) REQUIREMENTS.—Each report sub-  
21               mitted pursuant to subparagraph (A) shall in-  
22               clude the following:

23                   “(i) A description of the Secretary’s  
24                   efforts to implement this paragraph.

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

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

8 “(II) the name of each measure  
 9 developed;

10 “(III) the name of the developer  
 11 and steward of each measure;

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

16 “(V) whether the measure would  
 17 be electronically specified.

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

20 “(I) the information described in  
 21 clause (ii), if available; and

22 “(II) a timeline for completion of  
 23 the development of such measures.

24 “(iv) A description of any updates to  
 25 the plan under paragraph (1) (including

1 newly identified gaps and the status of pre-  
 2 viously identified gaps) and the inventory  
 3 of measures applicable under the applicable  
 4 provisions.

5 “(v) Other information the Secretary  
 6 determines to be appropriate.

7 “(4) STAKEHOLDER INPUT.—With respect to  
 8 paragraph (1), the Secretary shall seek stakeholder  
 9 input with respect to—

10 “(A) the identification of gaps where no  
 11 quality measures exist, particularly with respect  
 12 to the types of measures described in paragraph  
 13 (1)(D);

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

16 “(C) other areas related to quality measure  
 17 development determined appropriate by the Sec-  
 18 retary.

19 “(5) DEFINITION OF APPLICABLE PROVI-  
 20 SIONS.—In this subsection, the term ‘applicable pro-  
 21 visions’ means the following provisions:

22 “(A) Subsection (q)(2)(B)(i).

23 “(B) Section 1833(z)(2)(C).

24 “(6) FUNDING.—For purposes of carrying out  
 25 this subsection, the Secretary shall provide for the



1 transfer, from the Federal Supplementary Medical  
 2 Insurance Trust Fund under section 1841, of  
 3 \$15,000,000 to the Centers for Medicare & Medicaid  
 4 Services Program Management Account for each of  
 5 fiscal years 2014 through 2018. Amounts trans-  
 6 ferred under this paragraph shall remain available  
 7 through the end of fiscal year 2021.”.

8 **SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVID-**  
 9 **UALS WITH CHRONIC CARE NEEDS.**

10 (a) IN GENERAL.—Section 1848(b) of the Social Se-  
 11 curity Act (42 U.S.C. 1395w–4(b)) is amended by adding  
 12 at the end the following new paragraph:

13 “(8) ENCOURAGING CARE MANAGEMENT FOR  
 14 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

15 “(A) IN GENERAL.—In order to encourage  
 16 the management of care by an applicable pro-  
 17 vider (as defined in subparagraph (B)) for indi-  
 18 viduals with chronic care needs the Secretary  
 19 shall—

20 “(i) establish one or more HCPCS  
 21 codes for chronic care management serv-  
 22 ices for such individuals; and

23 “(ii) subject to subparagraph (D),  
 24 make payment (as the Secretary deter-  
 25 mines to be appropriate) under this section

1 for such management services furnished on  
 2 or after January 1, 2015, by an applicable  
 3 provider.

4 “(B) APPLICABLE PROVIDER DEFINED.—

5 For purposes of this paragraph, the term ‘ap-  
 6 plicable provider’ means a physician (as defined  
 7 in section 1861(r)(1)), physician assistant or  
 8 nurse practitioner (as defined in section  
 9 1861(aa)(5)(A)), or clinical nurse specialist (as  
 10 defined in section 1861(aa)(5)(B)) who fur-  
 11 nishes services as part of a patient-centered  
 12 medical home or a comparable specialty practice  
 13 that—

14 “(i) is recognized as such a medical  
 15 home or comparable specialty practice by  
 16 an organization that is recognized by the  
 17 Secretary for purposes of such recognition  
 18 as such a medical home or practice; or

19 “(ii) meets such other comparable  
 20 qualifications as the Secretary determines  
 21 to be appropriate.

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

1 “(D) POLICIES RELATING TO PAYMENT.—

2 In carrying out this paragraph, with respect to  
3 chronic care management services, the Sec-  
4 retary shall—

5 “(i) make payment to only one appli-  
6 cable provider for such services furnished  
7 to an individual during a period;

8 “(ii) not make payment under sub-  
9 paragraph (A) if such payment would be  
10 duplicative of payment that is otherwise  
11 made under this title for such services  
12 (such as in the case of hospice care or  
13 home health services); and

14 “(iii) not require that an annual  
15 wellness visit (as defined in section  
16 1861(hhh)) or an initial preventive phys-  
17 ical examination (as defined in section  
18 1861(ww)) be furnished as a condition of  
19 payment for such management services.”.

20 (b) EDUCATION AND OUTREACH.—

21 (1) CAMPAIGN.—

22 (A) IN GENERAL.—The Secretary of  
23 Health and Human Services (in this subsection  
24 referred to as the “Secretary”) shall conduct an  
25 education and outreach campaign to inform

1 professionals who furnish items and services  
2 under part B of title XVIII of the Social Secu-  
3 rity Act and individuals enrolled under such  
4 part of the benefits of chronic care management  
5 services described in section 1848(b)(8) of the  
6 Social Security Act, as added by subsection (a),  
7 and encourage such individuals with chronic  
8 care needs to receive such services.

9 (B) REQUIREMENTS.—Such campaign  
10 shall—

11 (i) be directed by the Office of Rural  
12 Health Policy of the Department of Health  
13 and Human Services and the Office of Mi-  
14 nority Health of the Centers for Medicare  
15 & Medicaid Services; and

16 (ii) focus on encouraging participation  
17 by underserved rural populations and ra-  
18 cial and ethnic minority populations.

19 (2) REPORT.—

20 (A) IN GENERAL.—Not later than Decem-  
21 ber 31, 2017, the Secretary shall submit to  
22 Congress a report on the use of chronic care  
23 management services described in such section  
24 1848(b)(8) by individuals living in rural areas

and by racial and ethnic minority populations.

Such report shall—

(i) identify barriers to receiving chronic care management services; and

(ii) make recommendations for increasing the appropriate use of chronic care management services.

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

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

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

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

“(i) COLLECTION OF INFORMATION.—  
Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee

1 schedule established under subsection (b).  
2 Such information may be collected or ob-  
3 tained from any eligible professional or any  
4 other source.

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

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

17 “(I) Time involved in furnishing  
18 services.

19 “(II) Amounts and types of prac-  
20 tice expense inputs involved with fur-  
21 nishing services.

22 “(III) Prices (net of any dis-  
23 counts) for practice expense inputs,  
24 which may include paid invoice prices  
25 or other documentation or records.

1 “(IV) Overhead and accounting  
 2 information for practices of physicians  
 3 and other suppliers.

4 “(V) Any other element that  
 5 would improve the valuation of serv-  
 6 ices under this section.

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

11 “(I) Surveys of physicians, other  
 12 suppliers, providers of services, manu-  
 13 facturers, and vendors.

14 “(II) Surgical logs, billing sys-  
 15 tems, or other practice or facility  
 16 records.

17 “(III) Electronic health records.

18 “(IV) Any other mechanism de-  
 19 termined appropriate by the Sec-  
 20 retary.

21 “(v) TRANSPARENCY OF USE OF IN-  
 22 FORMATION.—

23 “(I) IN GENERAL.—Subject to  
 24 subclauses (II) and (III), if the Sec-  
 25 retary uses information collected or

1 obtained under this subparagraph in  
2 the determination of relative values  
3 under this subsection, the Secretary  
4 shall disclose the information source  
5 and discuss the use of such informa-  
6 tion in such determination of relative  
7 values through notice and comment  
8 rulemaking.

9 “(II) THRESHOLDS FOR USE.—

10 The Secretary may establish thresh-  
11 olds in order to use such information,  
12 including the exclusion of information  
13 collected or obtained from eligible pro-  
14 fessionals who use very high resources  
15 (as determined by the Secretary) in  
16 furnishing a service.

17 “(III) DISCLOSURE OF INFORMA-

18 TION.—The Secretary shall make ag-  
19 gregate information available under  
20 this subparagraph but shall not dis-  
21 close information in a form or manner  
22 that identifies an eligible professional  
23 or a group practice, or information  
24 collected or obtained pursuant to a  
25 nondisclosure agreement.



1 “(vi) INCENTIVE TO PARTICIPATE.—

2 The Secretary may provide for such pay-  
3 ments under this part to an eligible profes-  
4 sional that submits such solicited informa-  
5 tion under this subparagraph as the Sec-  
6 retary determines appropriate in order to  
7 compensate such eligible professional for  
8 such submission. Such payments shall be  
9 provided in a form and manner specified  
10 by the Secretary.

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

15 “(viii) DEFINITION OF ELIGIBLE PRO-  
16 FESSIOAL.—In this subparagraph, the  
17 term ‘eligible professional’ has the meaning  
18 given such term in subsection (k)(3)(B).

19 “(ix) FUNDING.—For purposes of car-  
20 rying out this subparagraph, in addition to  
21 funds otherwise appropriated, the Sec-  
22 retary shall provide for the transfer, from  
23 the Federal Supplementary Medical Insur-  
24 ance Trust Fund under section 1841, of  
25 \$2,000,000 to the Centers for Medicare &

1 Medicaid Services Program Management  
 2 Account for each fiscal year beginning with  
 3 fiscal year 2014. Amounts transferred  
 4 under the preceding sentence for a fiscal  
 5 year shall be available until expended.”.

6 (2) LIMITATION ON REVIEW.—Section  
 7 1848(i)(1) of the Social Security Act (42 U.S.C.  
 8 1395w-4(i)(1)) is amended—

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

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

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

15 “(F) the collection and use of information  
 16 in the determination of relative values under  
 17 subsection (c)(2)(M).”.

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

24 “(N) AUTHORITY FOR ALTERNATIVE AP-  
 25 PROACHES TO ESTABLISHING PRACTICE EX-

1 PENSE RELATIVE VALUES.—The Secretary may  
 2 establish or adjust practice expense relative val-  
 3 ues under this subsection using cost, charge, or  
 4 other data from suppliers or providers of serv-  
 5 ices, including information collected or obtained  
 6 under subparagraph (M).”.

7 (c) REVISED AND EXPANDED IDENTIFICATION OF  
 8 POTENTIALLY MISVALUED CODES.—Section  
 9 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.  
 10 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

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

18 “(I) Codes that have experienced  
 19 the fastest growth.

20 “(II) Codes that have experi-  
 21 enced substantial changes in practice  
 22 expenses.

23 “(III) Codes that describe new  
 24 technologies or services within an ap-  
 25 propriate time period (such as 3

1 years) after the relative values are ini-  
2 tially established for such codes.

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

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

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

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

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

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

24 “(X) Codes for which there is a  
25 significant difference in payment for

1 the same service between different  
2 sites of service.

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

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

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

12 “(XIV) Codes with high practice  
13 expense relative value units.

14 “(XV) Codes with high cost sup-  
15 plies.

16 “(XVI) Codes as determined ap-  
17 propriate by the Secretary.”.

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

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

24 “(O) TARGET FOR RELATIVE VALUE AD-  
25 JUSTMENTS FOR MISVALUED SERVICES.—With

1           respect to fee schedules established for each of  
2           2015 through 2018, the following shall apply:

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

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

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

24                       “(II) the amount by which such  
25                       reduced expenditures exceeds the tar-

1           get for the year shall be treated as a  
 2           reduction in expenditures described in  
 3           clause (i) for the succeeding year, for  
 4           purposes of determining whether the  
 5           target has or has not been met under  
 6           this subparagraph with respect to that  
 7           year.

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

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

23               “(I) the target for the year; and

1 “(II) the estimated net reduction  
 2 in expenditures determined under  
 3 clause (i) for the year.

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

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

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

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

23 (1) IN GENERAL.—Section 1848(c) of the So-  
 24 cial Security Act (42 U.S.C. 1395w–4(c)) is amend-



1 ed by adding at the end the following new para-  
 2 graph:

3 “(7) PHASE-IN OF SIGNIFICANT RELATIVE  
 4 VALUE UNIT (RVU) REDUCTIONS.—Effective for fee  
 5 schedules established beginning with 2015, if the  
 6 total relative value units for a service for a year  
 7 would otherwise be decreased by an estimated  
 8 amount equal to or greater than 20 percent as com-  
 9 pared to the total relative value units for the pre-  
 10 vious year, the applicable adjustments in work, prac-  
 11 tice expense, and malpractice relative value units  
 12 shall be phased-in over a 2-year period.”.

13 (2) CONFORMING AMENDMENTS.—Section  
 14 1848(c)(2) of the Social Security Act (42 U.S.C.  
 15 1395w-4(c)(2)) is amended—

16 (A) in subparagraph (B)(ii)(I), by striking  
 17 “subclause (II)” and inserting “subclause (II)  
 18 and paragraph (7)”; and

19 (B) in subparagraph (K)(iii)(VI)—

20 (i) by striking “provisions of subpara-  
 21 graph (B)(ii)(II)” and inserting “provi-  
 22 sions of subparagraph (B)(ii)(II) and para-  
 23 graph (7)”; and

1 (ii) by striking “under subparagraph  
 2 (B)(ii)(II)” and inserting “under subpara-  
 3 graph (B)(ii)(I)”.

4 (f) AUTHORITY TO SMOOTH RELATIVE VALUES  
 5 WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of  
 6 the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)) is  
 7 amended—

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

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

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

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

24 (2) REPORT.—Not later than 1 year after the  
 25 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report containing  
 2 the results of the study conducted under paragraph  
 3 (1).

4 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-  
 5 ITIES.—

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

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

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

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

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

4           “(B) TRANSITION FOR MSAS PREVIOUSLY  
5           IN REST-OF-STATE PAYMENT LOCALITY OR IN  
6           LOCALITY 3.—

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

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

1                   “(II)     MSA-BASED     COMPO-  
 2                   NENT.—The   MSA-based   weighting  
 3                   factor (described in clause (iii)) for  
 4                   such year multiplied by the geographic  
 5                   index values computed for the fee  
 6                   schedule area under subparagraph (A)  
 7                   for the year (determined without re-  
 8                   gard to this subparagraph).

9                   “(ii) OLD WEIGHTING FACTOR.—The  
 10                  old weighting factor described in this  
 11                  clause—

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

13                   “(II) for each succeeding year, is  
 14                  the old weighting factor described in  
 15                  this clause for the previous year  
 16                  minus  $\frac{1}{6}$ .

17                   “(iii) MSA-BASED WEIGHTING FAC-  
 18                  TOR.—The   MSA-based   weighting factor  
 19                  described in this clause for a year is 1  
 20                  minus the old weighting factor under  
 21                  clause (ii) for that year.

22                   “(C) HOLD HARMLESS.—For services fur-  
 23                  nished in a transition area in California during  
 24                  a year beginning with 2017, the geographic  
 25                  index values to be applied under this subsection

1 for such year shall not be less than the cor-  
 2 responding geographic index values that would  
 3 have applied in such transition area (as esti-  
 4 mated by the Secretary) if this paragraph did  
 5 not apply.

6 “(D) TRANSITION AREA DEFINED.—In  
 7 this paragraph, the term ‘transition area’  
 8 means each of the following fee schedule areas  
 9 for 2013:

10 “(i) The rest-of-State payment local-  
 11 ity.

12 “(ii) Payment locality 3.

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

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

1 (i) DISCLOSURE OF DATA USED TO ESTABLISH  
2 MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—

3 The Secretary of Health and Human Services shall make  
4 publicly available the information used to establish the  
5 multiple procedure payment reduction policy to the profes-  
6 sional component of imaging services in the final rule pub-  
7 lished in the Federal Register, v. 77, n. 222, November  
8 16, 2012, pages 68891–69380 under the physician fee  
9 schedule under section 1848 of the Social Security Act (42  
10 U.S.C. 1395w–4).

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

12 (a) IN GENERAL.—Section 1834 of the Social Secu-  
13 rity Act (42 U.S.C. 1395m) is amended by adding at the  
14 end the following new subsection:

15 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR  
16 CERTAIN IMAGING SERVICES.—

17 “(1) PROGRAM ESTABLISHED.—

18 “(A) IN GENERAL.—The Secretary shall  
19 establish a program to promote the use of ap-  
20 propriate use criteria (as defined in subpara-  
21 graph (B)) for applicable imaging services (as  
22 defined in subparagraph (C)) furnished in an  
23 applicable setting (as defined in subparagraph  
24 (D)) by ordering professionals and furnishing

professionals (as defined in subparagraphs (E) and (F), respectively).

“(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term ‘appropriate use criteria’ means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

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

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

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

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



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

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

“(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term ‘furnishing professional’ means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

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

“(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders,

1 specify applicable appropriate use criteria for  
2 applicable imaging services only from among  
3 appropriate use criteria developed or endorsed  
4 by national professional medical specialty soci-  
5 eties or other provider-led entities.

6 “(B) CONSIDERATIONS.—In specifying ap-  
7 plicable appropriate use criteria under subpara-  
8 graph (A), the Secretary shall take into account  
9 whether the criteria—

10 “(i) have stakeholder consensus;

11 “(ii) are scientifically valid and evi-  
12 dence based; and

13 “(iii) are based on studies that are  
14 published and reviewable by stakeholders.

15 “(C) REVISIONS.—The Secretary shall re-  
16 view, on an annual basis, the specified applica-  
17 ble appropriate use criteria to determine if  
18 there is a need to update or revise (as appro-  
19 priate) such specification of applicable appro-  
20 priate use criteria and make such updates or  
21 revisions through rulemaking.

22 “(D) TREATMENT OF MULTIPLE APPLICA-  
23 BLE APPROPRIATE USE CRITERIA.—In the case  
24 where the Secretary determines that more than  
25 one appropriate use criteria applies with respect

1 to an applicable imaging service, the Secretary  
2 shall permit one or more applicable appropriate  
3 use criteria under this paragraph for the serv-  
4 ice.

5 “(3) MECHANISMS FOR CONSULTATION WITH  
6 APPLICABLE APPROPRIATE USE CRITERIA.—

7 “(A) IDENTIFICATION OF MECHANISMS TO  
8 CONSULT WITH APPLICABLE APPROPRIATE USE  
9 CRITERIA.—

10 “(i) IN GENERAL.—The Secretary  
11 shall specify qualified clinical decision sup-  
12 port mechanisms that could be used by or-  
13 dering professionals to consult with appli-  
14 cable appropriate use criteria for applicable  
15 imaging services.

16 “(ii) CONSULTATION.—The Secretary  
17 shall consult with physicians, practitioners,  
18 health care technology experts, and other  
19 stakeholders in specifying mechanisms  
20 under this paragraph.

21 “(iii) INCLUSION OF CERTAIN MECHA-  
22 NISMS.—Mechanisms specified under this  
23 paragraph may include any or all of the  
24 following that meet the requirements de-  
25 scribed in subparagraph (B)(ii):

1                   “(I) Use of clinical decision sup-  
 2                   port modules in certified EHR tech-  
 3                   nology (as defined in section  
 4                   1848(o)(4)).

5                   “(II) Use of private sector clin-  
 6                   ical decision support mechanisms that  
 7                   are independent from certified EHR  
 8                   technology, which may include use of  
 9                   clinical decision support mechanisms  
 10                  available from medical specialty orga-  
 11                  nizations.

12                  “(III) Use of a clinical decision  
 13                  support mechanism established by the  
 14                  Secretary.

15                  “(B) QUALIFIED CLINICAL DECISION SUP-  
 16                  PORT MECHANISMS.—

17                  “(i) IN GENERAL.—For purposes of  
 18                  this subsection, a qualified clinical decision  
 19                  support mechanism is a mechanism that  
 20                  the Secretary determines meets the re-  
 21                  quirements described in clause (ii).

22                  “(ii) REQUIREMENTS.—The require-  
 23                  ments described in this clause are the fol-  
 24                  lowing:

1           “(I) The mechanism makes avail-  
2           able to the ordering professional appli-  
3           cable appropriate use criteria specified  
4           under paragraph (2) and the sup-  
5           porting documentation for the applica-  
6           ble imaging service ordered.

7           “(II) In the case where there are  
8           more than one applicable appropriate  
9           use criteria specified under such para-  
10          graph for an applicable imaging serv-  
11          ice, the mechanism indicates the cri-  
12          teria that it uses for the service.

13          “(III) The mechanism determines  
14          the extent to which an applicable im-  
15          aging service ordered is consistent  
16          with the applicable appropriate use  
17          criteria so specified.

18          “(IV) The mechanism generates  
19          and provides to the ordering profes-  
20          sional a certification or documentation  
21          that documents that the qualified clin-  
22          ical decision support mechanism was  
23          consulted by the ordering professional.

24          “(V) The mechanism is updated  
25          on a timely basis to reflect revisions

1 to the specification of applicable ap-  
 2 propriate use criteria under such  
 3 paragraph.

4 “(VI) The mechanism meets pri-  
 5 vacy and security standards under ap-  
 6 plicable provisions of law.

7 “(VII) The mechanism performs  
 8 such other functions as specified by  
 9 the Secretary, which may include a re-  
 10 quirement to provide aggregate feed-  
 11 back to the ordering professional.

12 “(C) LIST OF MECHANISMS FOR CON-  
 13 SULTATION WITH APPLICABLE APPROPRIATE  
 14 USE CRITERIA.—

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

19 “(ii) PERIODIC UPDATING OF LIST.—  
 20 The Secretary shall identify on an annual  
 21 basis the list of qualified clinical decision  
 22 support mechanisms specified under this  
 23 paragraph.

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

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

9                   “(i) consult with a qualified decision  
10                  support mechanism listed under paragraph  
11                  (3)(C); and

12                  “(ii) provide to the furnishing profes-  
13                  sional the information described in clauses  
14                  (i) through (iii) of subparagraph (B).

15           “(B) REPORTING BY FURNISHING PROFES-  
16           SIONAL.—Beginning with January 1, 2017,  
17           subject to subparagraph (C), with respect to an  
18           applicable imaging service furnished in an ap-  
19           plicable setting and paid for under an applica-  
20           ble payment system (as defined in subpara-  
21           graph (D)), payment for such service may only  
22           be made if the claim for the service includes the  
23           following:

24                   “(i) Information about which qualified  
25                  clinical decision support mechanism was

1 consulted by the ordering professional for  
2 the service.

3 “(ii) Information regarding—

4 “(I) whether the service ordered  
5 would adhere to the applicable appro-  
6 priate use criteria specified under  
7 paragraph (2);

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

10 “(III) whether such criteria was  
11 not applicable to the service ordered.

12 “(iii) The national provider identifier  
13 of the ordering professional (if different  
14 from the furnishing professional).

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

18 “(i) EMERGENCY SERVICES.—An ap-  
19 plicable imaging service ordered for an in-  
20 dividual with an emergency medical condi-  
21 tion (as defined in section 1867(e)(1)).

22 “(ii) INPATIENT SERVICES.—An appli-  
23 cable imaging service ordered for an inpa-  
24 tient and for which payment is made under  
25 part A.



1 “(iii) ALTERNATIVE PAYMENT MOD-  
 2 ELS.—An applicable imaging service or-  
 3 dered by an ordering professional with re-  
 4 spect to an individual attributed to an al-  
 5 ternative payment model (as defined in  
 6 section 1833(z)(3)(C)).

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

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

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

23 “(ii) The prospective payment system  
 24 for hospital outpatient department services  
 25 under section 1833(t).

1 “(iii) The ambulatory surgical center  
2 payment systems under section 1833(i).

3 “(5) IDENTIFICATION OF OUTLIER ORDERING  
4 PROFESSIONALS.—

5 “(A) IN GENERAL.—With respect to appli-  
6 cable imaging services furnished beginning with  
7 2017, the Secretary shall determine, on an an-  
8 nual basis, no more than five percent of the  
9 total number of ordering professionals who are  
10 outlier ordering professionals.

11 “(B) OUTLIER ORDERING PROFES-  
12 SIONALS.—The determination of an outlier or-  
13 dering professional shall—

14 “(i) be based on low adherence to ap-  
15 plicable appropriate use criteria specified  
16 under paragraph (2), which may be based  
17 on comparison to other ordering profes-  
18 sionals; and

19 “(ii) include data for ordering profes-  
20 sionals for whom prior authorization under  
21 paragraph (6)(A) applies.

22 “(C) USE OF TWO YEARS OF DATA.—The  
23 Secretary shall use two years of data to identify  
24 outlier ordering professionals under this para-  
25 graph.

1           “(D) PROCESS.—The Secretary shall es-  
 2           tablish a process for determining when an  
 3           outlier ordering professional is no longer an  
 4           outlier ordering professional.

5           “(E) CONSULTATION WITH STAKE-  
 6           HOLDERS.—The Secretary shall consult with  
 7           physicians, practitioners and other stakeholders  
 8           in developing methods to identify outlier order-  
 9           ing professionals under this paragraph.

10          “(6) PRIOR AUTHORIZATION FOR ORDERING  
 11          PROFESSIONALS WHO ARE OUTLIERS.—

12           “(A) IN GENERAL.—Beginning January 1,  
 13           2020, subject to paragraph (4)(C), with respect  
 14           to services furnished during a year, the Sec-  
 15           retary shall, for a period determined appro-  
 16           priate by the Secretary, apply prior authoriza-  
 17           tion for applicable imaging services that are or-  
 18           dered by an outlier ordering professional identi-  
 19           fied under paragraph (5).

20           “(B) APPROPRIATE USE CRITERIA IN  
 21           PRIOR AUTHORIZATION.—In applying prior au-  
 22           thorization under subparagraph (A), the Sec-  
 23           retary shall utilize only the applicable appro-  
 24           priate use criteria specified under this sub-  
 25           section.

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

11          “(7) CONSTRUCTION.—Nothing in this sub-  
 12          section shall be construed as granting the Secretary  
 13          the authority to develop or initiate the development  
 14          of clinical practice guidelines or appropriate use cri-  
 15          teria.”.

16          (b)           CONFORMING           AMENDMENT.—Section  
 17          1833(t)(16) of the Social Security Act (42 U.S.C.  
 18          1395l(t)(16)) is amended by adding at the end the fol-  
 19          lowing new subparagraph:

20               “(E) APPLICATION OF APPROPRIATE USE  
 21               CRITERIA FOR CERTAIN IMAGING SERVICES.—  
 22               For provisions relating to the application of ap-  
 23               propriate use criteria for certain imaging serv-  
 24               ices, see section 1834(p).”.

1       (c) REPORT ON EXPERIENCE OF IMAGING APPRO-  
2 PRIATE USE CRITERIA PROGRAM.—Not later than 18  
3 months after the date of the enactment of this Act, the  
4 Comptroller General of the United States shall submit to  
5 Congress a report that includes a description of the extent  
6 to which appropriate use criteria could be used for other  
7 services under part B of title XVIII of the Social Security  
8 Act (42 U.S.C. 1395j et seq.), such as radiation therapy  
9 and clinical diagnostic laboratory services.

10 **SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH**  
11 **ACCESS TO INFORMATION ON PHYSICIANS’**  
12 **SERVICES.**

13       (a) IN GENERAL.—The Secretary shall make publicly  
14 available on Physician Compare the information described  
15 in subsection (b) with respect to eligible professionals.

16       (b) INFORMATION DESCRIBED.—The following infor-  
17 mation, with respect to an eligible professional, is de-  
18 scribed in this subsection:

19           (1) Information on the number of services fur-  
20 nished by the eligible professional under part B of  
21 title XVIII of the Social Security Act (42 U.S.C.  
22 1395j et seq.), which may include information on the  
23 most frequent services furnished or groupings of  
24 services.

1           (2) Information on submitted charges and pay-  
2           ments for services under such part.

3           (3) A unique identifier for the eligible profes-  
4           sional that is available to the public, such as a na-  
5           tional provider identifier.

6           (c) SEARCHABILITY.—The information made avail-  
7           able under this section shall be searchable by at least the  
8           following:

9           (1) The specialty or type of the eligible profes-  
10          sional.

11          (2) Characteristics of the services furnished,  
12          such as volume or groupings of services.

13          (3) The location of the eligible professional.

14          (d) DISCLOSURE.—The information made available  
15          under this section shall indicate, where appropriate, that  
16          publicized information may not be representative of the  
17          eligible professional's entire patient population, the variety  
18          of services furnished by the eligible professional, or the  
19          health conditions of individuals treated.

20          (e) IMPLEMENTATION.—

21                (1) INITIAL IMPLEMENTATION.—Physician  
22          Compare shall include the information described in  
23          subsection (b)—

24                        (A) with respect to physicians, by not later  
25                        than July 1, 2015; and

1 (B) with respect to other eligible profes-  
 2 sionals, by not later than July 1, 2016.

3 (2) ANNUAL UPDATING.—The information  
 4 made available under this section shall be updated  
 5 on Physician Compare not less frequently than on  
 6 an annual basis.

7 (f) OPPORTUNITY TO REVIEW AND SUBMIT CORREC-  
 8 TIONS.—The Secretary shall provide for an opportunity  
 9 for an eligible professional to review, and submit correc-  
 10 tions for, the information to be made public with respect  
 11 to the eligible professional under this section prior to such  
 12 information being made public.

13 (g) DEFINITIONS.—In this section:

14 (1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SEC-  
 15 RETARY.—The terms “eligible professional”, “physi-  
 16 cian”, and “Secretary” have the meaning given such  
 17 terms in section 10331(i) of Public Law 111–148.

18 (2) PHYSICIAN COMPARE.—The term “Physi-  
 19 cian Compare” means the Physician Compare Inter-  
 20 net website of the Centers for Medicare & Medicaid  
 21 Services (or a successor website).

22 **SEC. 8. EXPANDING AVAILABILITY OF MEDICARE DATA.**

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

25 (1) ADDITIONAL ANALYSES.—

1 (A) IN GENERAL.—Subject to subpara-  
2 graph (B), to the extent consistent with appli-  
3 cable information, privacy, security, and diselo-  
4 sure laws (including paragraph (3)), notwith-  
5 standing paragraph (4)(B) of section 1874(e) of  
6 the Social Security Act (42 U.S.C. 1395kk(e))  
7 and the second sentence of paragraph (4)(D) of  
8 such section, beginning July 1, 2015, a quali-  
9 fied entity may use the combined data described  
10 in paragraph (4)(B)(iii) of such section received  
11 by such entity under such section, and informa-  
12 tion derived from the evaluation described in  
13 such paragraph (4)(D), to conduct additional  
14 non-public analyses (as determined appropriate  
15 by the Secretary) and provide or sell such anal-  
16 yses to authorized users for non-public use (in-  
17 cluding for the purposes of assisting providers  
18 of services and suppliers to develop and partici-  
19 pate in quality and patient care improvement  
20 activities, including developing new models of  
21 care).

22 (B) LIMITATIONS WITH RESPECT TO ANAL-  
23 YSES.—

24 (i) EMPLOYERS.—Any analyses pro-  
25 vided or sold under subparagraph (A) to



1 an employer described in paragraph  
 2 (9)(A)(iii) may only be used by such em-  
 3 ployer for purposes of providing health in-  
 4 surance to employees and retirees of the  
 5 employer.

6 (ii) HEALTH INSURANCE ISSUERS.—A  
 7 qualified entity may not provide or sell an  
 8 analysis to a health insurance issuer de-  
 9 scribed in paragraph (9)(A)(iv) unless the  
 10 issuer is providing the qualified entity with  
 11 data under section 1874(e)(4)(B)(iii) of  
 12 the Social Security Act (42 U.S.C.  
 13 1395kk(e)(4)(B)(iii)).

14 (2) ACCESS TO CERTAIN DATA.—

15 (A) ACCESS.—To the extent consistent  
 16 with applicable information, privacy, security,  
 17 and disclosure laws (including paragraph (3)),  
 18 notwithstanding paragraph (4)(B) of section  
 19 1874(e) of the Social Security Act (42 U.S.C.  
 20 1395kk(e)) and the second sentence of para-  
 21 graph (4)(D) of such section, beginning July 1,  
 22 2015, a qualified entity may—

23 (i) provide or sell the combined data  
 24 described in paragraph (4)(B)(iii) of such  
 25 section to authorized users described in

1 clauses (i), (ii), and (v) of paragraph  
 2 (9)(A) for non-public use, including for the  
 3 purposes described in subparagraph (B);  
 4 or

5 (ii) subject to subparagraph (C), pro-  
 6 vide Medicare claims data to authorized  
 7 users described in clauses (i), (ii), and (v),  
 8 of paragraph (9)(A) for non-public use, in-  
 9 cluding for the purposes described in sub-  
 10 paragraph (B).

11 (B) PURPOSES DESCRIBED.—The purposes  
 12 described in this subparagraph are assisting  
 13 providers of services and suppliers in developing  
 14 and participating in quality and patient care  
 15 improvement activities, including developing  
 16 new models of care.

17 (C) MEDICARE CLAIMS DATA MUST BE  
 18 PROVIDED AT NO COST.—A qualified entity may  
 19 not charge a fee for providing the data under  
 20 subparagraph (A)(ii).

21 (3) PROTECTION OF INFORMATION.—

22 (A) IN GENERAL.—Except as provided in  
 23 subparagraph (B), an analysis or data that is  
 24 provided or sold under paragraph (1) or (2)

1 shall not contain information that individually  
2 identifies a patient.

3 (B) INFORMATION ON PATIENTS OF THE  
4 PROVIDER OF SERVICES OR SUPPLIER.—To the  
5 extent consistent with applicable information,  
6 privacy, security, and disclosure laws, an anal-  
7 ysis or data that is provided or sold to a pro-  
8 vider of services or supplier under paragraph  
9 (1) or (2) may contain information that individ-  
10 ually identifies a patient of such provider or  
11 supplier, including with respect to items and  
12 services furnished to the patient by other pro-  
13 viders of services or suppliers.

14 (C) PROHIBITION ON USING ANALYSES OR  
15 DATA FOR MARKETING PURPOSES.—An author-  
16 ized user shall not use an analysis or data pro-  
17 vided or sold under paragraph (1) or (2) for  
18 marketing purposes.

19 (4) DATA USE AGREEMENT.—A qualified entity  
20 and an authorized user described in clauses (i), (ii),  
21 and (v) of paragraph (9)(A) shall enter into an  
22 agreement regarding the use of any data that the  
23 qualified entity is providing or selling to the author-  
24 ized user under paragraph (2). Such agreement shall  
25 describe the requirements for privacy and security of

1 the data and, as determined appropriate by the Sec-  
2 retary, any prohibitions on using such data to link  
3 to other individually identifiable sources of informa-  
4 tion. If the authorized user is not a covered entity  
5 under the rules promulgated pursuant to the Health  
6 Insurance Portability and Accountability Act of  
7 1996, the agreement shall identify the relevant regu-  
8 lations, as determined by the Secretary, that the  
9 user shall comply with as if it were acting in the ca-  
10 pacity of such a covered entity.

11 (5) NO REDISCLOSURE OF ANALYSES OR  
12 DATA.—

13 (A) IN GENERAL.—Except as provided in  
14 subparagraph (B), an authorized user that is  
15 provided or sold an analysis or data under  
16 paragraph (1) or (2) shall not redisclose or  
17 make public such analysis or data or any anal-  
18 ysis using such data.

19 (B) PERMITTED REDISCLOSURE.—A pro-  
20 vider of services or supplier that is provided or  
21 sold an analysis or data under paragraph (1) or  
22 (2) may, as determined by the Secretary, redis-  
23 close such analysis or data for the purposes of  
24 performance improvement and care coordination

activities but shall not make public such analysis or data or any analysis using such data.

(6) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

(A) IN GENERAL.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

1 (B) ASSESSMENT.—The assessment under  
 2 subparagraph (A) shall be an amount up to  
 3 \$100 for each individual entitled to, or enrolled  
 4 for, benefits under part A of title XVIII of the  
 5 Social Security Act or enrolled for benefits  
 6 under part B of such title—

7 (i) in the case of an agreement de-  
 8 scribed in subparagraph (A)(i), for whom  
 9 the Secretary provided data on to the  
 10 qualified entity under paragraph (2); and

11 (ii) in the case of an agreement de-  
 12 scribed in subparagraph (A)(ii), for whom  
 13 the qualified entity provided data on to the  
 14 authorized user under paragraph (2).

15 (C) DEPOSIT OF AMOUNTS COLLECTED.—  
 16 Any amounts collected pursuant to this para-  
 17 graph shall be deposited in Federal Supple-  
 18 mentary Medical Insurance Trust Fund under  
 19 section 1841 of the Social Security Act (42  
 20 U.S.C. 1395t).

21 (8) ANNUAL REPORTS.—Any qualified entity  
 22 that provides or sells an analysis or data under  
 23 paragraph (1) or (2) shall annually submit to the  
 24 Secretary a report that includes—

1 (A) a summary of the analyses provided or  
 2 sold, including the number of such analyses, the  
 3 number of purchasers of such analyses, and the  
 4 total amount of fees received for such analyses;

5 (B) a description of the topics and pur-  
 6 poses of such analyses;

7 (C) information on the entities who re-  
 8 ceived the data under paragraph (2), the uses  
 9 of the data, and the total amount of fees re-  
 10 ceived for providing, selling, or sharing the  
 11 data; and

12 (D) other information determined appro-  
 13 priate by the Secretary.

14 (9) DEFINITIONS.—In this subsection and sub-  
 15 section (b):

16 (A) AUTHORIZED USER.—The term “au-  
 17 thorized user” means the following:

18 (i) A provider of services.

19 (ii) A supplier.

20 (iii) An employer (as defined in sec-  
 21 tion 3(5) of the Employee Retirement In-  
 22 surance Security Act of 1974).

23 (iv) A health insurance issuer (as de-  
 24 fined in section 2791 of the Public Health  
 25 Service Act).

1 (v) A medical society or hospital asso-  
2 ciation.

3 (vi) Any entity not described in  
4 clauses (i) through (v) that is approved by  
5 the Secretary (other than an employer or  
6 health insurance issuer not described in  
7 clauses (iii) and (iv), respectively, as deter-  
8 mined by the Secretary).

9 (B) PROVIDER OF SERVICES.—The term  
10 “provider of services” has the meaning given  
11 such term in section 1861(u) of the Social Se-  
12 curity Act (42 U.S.C. 1395x(u)).

13 (C) QUALIFIED ENTITY.—The term “quali-  
14 fied entity” has the meaning given such term in  
15 section 1874(e)(2) of the Social Security Act  
16 (42 U.S.C. 1395kk(e)).

17 (D) SECRETARY.—The term “Secretary”  
18 means the Secretary of Health and Human  
19 Services.

20 (E) SUPPLIER.—The term “supplier” has  
21 the meaning given such term in section 1861(d)  
22 of the Social Security Act (42 U.S.C.  
23 1395x(d)).



1 (b) ACCESS TO MEDICARE DATA BY QUALIFIED  
2 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY  
3 IMPROVEMENT.—

4 (1) ACCESS.—

5 (A) IN GENERAL.—To the extent con-  
6 sistent with applicable information, privacy, se-  
7 curity, and disclosure laws, beginning July 1,  
8 2015, the Secretary shall, at the request of a  
9 qualified clinical data registry under section  
10 1848(m)(3)(E) of the Social Security Act (42  
11 U.S.C. 1395w–4(m)(3)(E)), provide the data  
12 described in subparagraph (B) (in a form and  
13 manner determined to be appropriate) to such  
14 qualified clinical data registry for purposes of  
15 linking such data with clinical outcomes data  
16 and performing risk-adjusted, scientifically valid  
17 analyses and research to support quality im-  
18 provement or patient safety, provided that any  
19 public reporting of such analyses or research  
20 that identifies a provider of services or supplier  
21 shall only be conducted with the opportunity of  
22 such provider or supplier to appeal and correct  
23 errors in the manner described in subsection  
24 (a)(6).

1 (B) DATA DESCRIBED.—The data de-  
 2 scribed in this subparagraph is—

3 (i) claims data under the Medicare  
 4 program under title XVIII of the Social  
 5 Security Act; and

6 (ii) if the Secretary determines appro-  
 7 priate, claims data under the Medicaid  
 8 program under title XIX of such Act and  
 9 the State Children’s Health Insurance Pro-  
 10 gram under title XXI of such Act.

11 (2) FEE.—Data described in paragraph (1)(B)  
 12 shall be provided to a qualified clinical data registry  
 13 under paragraph (1) at a fee equal to the cost of  
 14 providing such data. Any fee collected pursuant to  
 15 the preceding sentence shall be deposited in the Cen-  
 16 ters for Medicare & Medicaid Services Program  
 17 Management Account.

18 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED  
 19 ENTITIES.—Section 1874(e) of the Social Security Act  
 20 (42 U.S.C. 1395kk(e)) is amended—

21 (1) in the subsection heading, by striking  
 22 “MEDICARE”; and

23 (2) in paragraph (3)—

24 (A) by inserting after the first sentence the  
 25 following new sentence: “Beginning July 1,

2015, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.”; and

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

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

(1) by inserting “, for periods prior to July 1, 2015,” after “deposited”; and

(2) by inserting the following before the period at the end: “, and, beginning July 1, 2015, into the Centers for Medicare & Medicaid Services Program Management Account”.

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

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

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

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

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

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

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

“(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term ‘applicable 2-year period’ means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary

(in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.”.

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

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

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

“(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—

The term ‘opt-out physician or practitioner’ means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).”;

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

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

1           “(5) POSTING OF INFORMATION ON OPT-OUT  
2       PHYSICIANS AND PRACTITIONERS.—

3           “(A) IN GENERAL.—Beginning not later  
4       than February 1, 2015, the Secretary shall  
5       make publicly available through an appropriate  
6       publicly accessible website of the Department of  
7       Health and Human Services information on the  
8       number and characteristics of opt-out physi-  
9       cians and practitioners and shall update such  
10      information on such website not less often than  
11      annually.

12          “(B) INFORMATION TO BE INCLUDED.—  
13      The information to be made available under  
14      subparagraph (A) shall include at least the fol-  
15      lowing with respect to opt-out physicians and  
16      practitioners:

17           “(i) Their number.

18           “(ii) Their physician or professional  
19      specialty or other designation.

20           “(iii) Their geographic distribution.

21           “(iv) The timing of their becoming  
22      opt-out physicians and practitioners, rel-  
23      ative to when they first entered practice  
24      and with respect to applicable 2-year peri-  
25      ods.

1                   “(v) The proportion of such physi-  
2                   cians and practitioners who billed for  
3                   emergency or urgent care services.”.

4           (b) GAINSHARING STUDY AND REPORT.—Not later  
5 than 6 months after the date of the enactment of this Act,  
6 the Secretary of Health and Human Services, in consulta-  
7 tion with the Inspector General of the Department of  
8 Health and Human Services, shall submit to Congress a  
9 report with legislative recommendations to amend existing  
10 fraud and abuse laws, through exceptions, safe harbors,  
11 or other narrowly targeted provisions, to permit  
12 gainsharing or similar arrangements between physicians  
13 and hospitals that improve care while reducing waste and  
14 increasing efficiency. The report shall—

15           (1) consider whether such provisions should  
16           apply to ownership interests, compensation arrange-  
17           ments, or other relationships;

18           (2) describe how the recommendations address  
19           accountability, transparency, and quality, including  
20           how best to limit inducements to stint on care, dis-  
21           charge patients prematurely, or otherwise reduce or  
22           limit medically necessary care; and

23           (3) consider whether a portion of any savings  
24           generated by such arrangements should accrue to

1 the Medicare program under title XVIII of the So-  
2 cial Security Act.

3 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC  
4 HEALTH RECORD SYSTEMS.—

5 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-  
6 SPREAD EHR INTEROPERABILITY.—

7 (A) OBJECTIVE.—As a consequence of a  
8 significant Federal investment in the implemen-  
9 tation of health information technology through  
10 the Medicare and Medicaid EHR incentive pro-  
11 grams, Congress declares it a national objective  
12 to achieve widespread exchange of health infor-  
13 mation through interoperable certified EHR  
14 technology nationwide by December 31, 2017.

15 (B) DEFINITIONS.—In this paragraph:

16 (i) WIDESPREAD INTEROPER-  
17 ABILITY.—The term “widespread inter-  
18 operability” means interoperability between  
19 certified EHR technology systems em-  
20 ployed by meaningful EHR users under  
21 the Medicare and Medicaid EHR incentive  
22 programs and other clinicians and health  
23 care providers on a nationwide basis.

24 (ii) INTEROPERABILITY.—The term  
25 “interoperability” means the ability of two



1 or more health information systems or  
2 components to exchange clinical and other  
3 information and to use the information  
4 that has been exchanged using common  
5 standards as to provide access to longitu-  
6 dinal information for health care providers  
7 in order to facilitate coordinated care and  
8 improved patient outcomes.

9 (C) ESTABLISHMENT OF METRICS.—Not  
10 later than July 1, 2015, and in consultation  
11 with stakeholders, the Secretary shall establish  
12 metrics to be used to determine if and to the  
13 extent that the objective described in subpara-  
14 graph (A) has been achieved.

15 (D) RECOMMENDATIONS IF OBJECTIVE  
16 NOT ACHIEVED.—If the Secretary of Health  
17 and Human Services determines that the objec-  
18 tive described in subparagraph (A) has not been  
19 achieved by December 31, 2017, then the Sec-  
20 retary shall submit to Congress a report, by not  
21 later than December 31, 2018, that identifies  
22 barriers to such objective and recommends ac-  
23 tions that the Federal Government can take to  
24 achieve such objective. Such recommended ac-  
25 tions may include recommendations—

(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w-4(o)(2)(A)(ii)) is amended by inserting before the period at the end the following: “, and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken any action to limit or restrict the compatibility or interoperability of the certified EHR technology”.

(B) FOR MEANINGFUL EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: “, and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hos-

1           pital has not knowingly and willfully taken any  
2           action to limit or restrict the compatibility or  
3           interoperability of the certified EHR tech-  
4           nology”.

5           (C) EFFECTIVE DATE.—The amendments  
6           made by this subsection shall apply to meaning-  
7           ful EHR users as of the date that is one year  
8           after the date of the enactment of this Act.

9           (3) STUDY AND REPORT ON THE FEASIBILITY  
10          OF ESTABLISHING A WEBSITE TO COMPARE CER-  
11          TIFIED EHR TECHNOLOGY PRODUCTS.—

12          (A) STUDY.—The Secretary shall conduct  
13          a study to examine the feasibility of estab-  
14          lishing mechanisms that includes aggregated re-  
15          sults of surveys of meaningful EHR users on  
16          the functionality of certified EHR technology  
17          products to enable such users to directly com-  
18          pare the functionality and other features of  
19          such products. Such information may be made  
20          available through contracts with physician, hos-  
21          pital, or other organizations that maintain such  
22          comparative information.

23          (B) REPORT.—Not later than 1 year after  
24          the date of the enactment of this Act, the Sec-  
25          retary shall submit to Congress a report on the

website. The report shall include information on the benefits of, and resources needed to develop and maintain, such a website.

(4) DEFINITIONS.—In this subsection:

(A) The term “certified EHR technology” has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w-4(o)(4)).

(B) The term “meaningful EHR user” has the meaning given such term under the Medicare EHR incentive programs.

(C) The term “Medicare and Medicaid EHR incentive programs” means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w-4(o), 1395w-23, 1395ww(n)); and

(ii) in the case of the Medicaid program under title XIX of such Act, the incentive program under subsections

1 (a)(3)(F) and (t) of section 1903 of such  
2 Act (42 U.S.C. 1396b).

3 (D) The term “Secretary” means the Sec-  
4 retary of Health and Human Services.

5 (d) GAO STUDIES AND REPORTS ON THE USE OF  
6 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-  
7 MOTE PATIENT MONITORING SERVICES.—

8 (1) STUDY ON TELEHEALTH SERVICES.—The  
9 Comptroller General of the United States shall con-  
10 duct a study on the following:

11 (A) How the definition of telehealth across  
12 various Federal programs and Federal efforts  
13 can inform the use of telehealth in the Medicare  
14 program under title XVIII of the Social Secu-  
15 rity Act (42 U.S.C. 1395 et seq.).

16 (B) Issues that can facilitate or inhibit the  
17 use of telehealth under the Medicare program  
18 under such title, including oversight and profes-  
19 sional licensure, changing technology, privacy  
20 and security, infrastructure requirements, and  
21 varying needs across urban and rural areas.

22 (C) Potential implications of greater use of  
23 telehealth with respect to payment and delivery  
24 system transformations under the Medicare  
25 program under such title XVIII and the Med-

1           icaid program under title XIX of such Act (42  
2           U.S.C. 1396 et seq.).

3           (D) How the Centers for Medicare & Med-  
4           icaid Services conducts oversight of payments  
5           made under the Medicare program under such  
6           title XVIII to providers for telehealth services.

7           (2) STUDY ON REMOTE PATIENT MONITORING  
8           SERVICES.—

9           (A) IN GENERAL.—The Comptroller Gen-  
10          eral of the United States shall conduct a  
11          study—

12                 (i) of the dissemination of remote pa-  
13                 tient monitoring technology in the private  
14                 health insurance market;

15                 (ii) of the financial incentives in the  
16                 private health insurance market relating to  
17                 adoption of such technology;

18                 (iii) of the barriers to adoption of  
19                 such services under the Medicare program  
20                 under title XVIII of the Social Security  
21                 Act;

22                 (iv) that evaluates the patients, condi-  
23                 tions, and clinical circumstances that could  
24                 most benefit from remote patient moni-  
25                 toring services; and

1 (v) that evaluates the challenges re-  
2 lated to establishing appropriate valuation  
3 for remote patient monitoring services  
4 under the Medicare physician fee schedule  
5 under section 1848 of the Social Security  
6 Act (42 U.S.C. 1395w-4) in order to accu-  
7 rately reflect the resources involved in fur-  
8 nishing such services.

9 (B) DEFINITIONS.—For purposes of this  
10 paragraph:

11 (i) REMOTE PATIENT MONITORING  
12 SERVICES.—The term “remote patient  
13 monitoring services” means services fur-  
14 nished through remote patient monitoring  
15 technology.

16 (ii) REMOTE PATIENT MONITORING  
17 TECHNOLOGY.—The term “remote patient  
18 monitoring technology” means a coordi-  
19 nated system that uses one or more home-  
20 based or mobile monitoring devices that  
21 automatically transmit vital sign data or  
22 information on activities of daily living and  
23 may include responses to assessment ques-  
24 tions collected on the devices wirelessly or  
25 through a telecommunications connection

1 to a server that complies with the Federal  
2 regulations (concerning the privacy of indi-  
3 vidually identifiable health information)  
4 promulgated under section 264(c) of the  
5 Health Insurance Portability and Account-  
6 ability Act of 1996, as part of an estab-  
7 lished plan of care for that patient that in-  
8 cludes the review and interpretation of that  
9 data by a health care professional.

10 (3) REPORTS.—Not later than 24 months after  
11 the date of the enactment of this Act, the Comp-  
12 troller General shall submit to Congress—

13 (A) a report containing the results of the  
14 study conducted under paragraph (1); and

15 (B) a report containing the results of the  
16 study conducted under paragraph (2).

17 A report required under this paragraph shall be sub-  
18 mitted together with recommendations for such leg-  
19 islation and administrative action as the Comptroller  
20 General determines appropriate. The Comptroller  
21 General may submit one report containing the re-  
22 sults described in subparagraphs (A) and (B) and  
23 the recommendations described in the previous sen-  
24 tence.



1 (e) RULE OF CONSTRUCTION REGARDING  
2 HEALTHCARE PROVIDER STANDARDS OF CARE.—

3 (1) MAINTENANCE OF STATE STANDARDS.—

4 The development, recognition, or implementation of  
5 any guideline or other standard under any Federal  
6 health care provision shall not be construed—

7 (A) to establish the standard of care or  
8 duty of care owed by a health care provider to  
9 a patient in any medical malpractice or medical  
10 product liability action or claim; or

11 (B) to preempt any standard of care or  
12 duty of care, owed by a health care provider to  
13 a patient, duly established under State or com-  
14 mon law.

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

17 (A) FEDERAL HEALTH CARE PROVISION.—

18 The term “Federal health care provision”  
19 means any provision of the Patient Protection  
20 and Affordable Care Act (Public Law 111–  
21 148), title I or subtitle B of title II of the  
22 Health Care and Education Reconciliation Act  
23 of 2010 (Public Law 111–152), or title XVIII  
24 or XIX of the Social Security Act.

1 (B) HEALTH CARE PROVIDER.—The term  
2 “health care provider” means any individual or  
3 entity—

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

7 (ii) required to be so licensed, reg-  
8 istered, or certified but that is exempted  
9 by other statute or regulation.

10 (C) MEDICAL MALPRACTICE OR MEDICAL  
11 PRODUCT LIABILITY ACTION OR CLAIM.—The  
12 term “medical malpractice or medical product  
13 liability action or claim” means a medical mal-  
14 practice action or claim (as defined in section  
15 431(7) of the Health Care Quality Improve-  
16 ment Act of 1986 (42 U.S.C. 11151(7))) and  
17 includes a liability action or claim relating to a  
18 health care provider’s prescription or provision  
19 of a drug, device, or biological product (as such  
20 terms are defined in section 201 of the Federal  
21 Food, Drug, and Cosmetic Act or section 351  
22 of the Public Health Service Act).

23 (D) STATE.—The term “State” includes  
24 the District of Columbia, Puerto Rico, and any

1           other commonwealth, possession, or territory of  
2           the United States.

3           (3) PRESERVATION OF STATE LAW.—No provi-  
4           sion of the Patient Protection and Affordable Care  
5           Act (Public Law 111–148), title I or subtitle B of  
6           title II of the Health Care and Education Reconcili-  
7           ation Act of 2010 (Public Law 111–152), or title  
8           XVIII or XIX of the Social Security Act shall be  
9           construed to preempt any State or common law gov-  
10          erning medical professional or medical product liabil-  
11          ity actions or claims.

○