

113TH CONGRESS  
2D SESSION

# H. R. 4015

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## AN ACT

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,*

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

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “SGR Repeal and Medicare Provider Payment Moderniza-  
4 tion Act of 2014”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians’ services.
- Sec. 3. Priorities and funding for 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.
- Sec. 10. Delay in implementation of penalty for failure to comply with individual health insurance mandate.

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

10 (a) STABILIZING FEE UPDATES.—

11 (1) REPEAL OF SGR PAYMENT METHOD-  
12 OLOGY.—Section 1848 of the Social Security Act  
13 (42 U.S.C. 1395w–4) is amended—

14 (A) in subsection (d)—

15 (i) in paragraph (1)(A), by inserting  
16 “or a subsequent paragraph” after “para-  
17 graph (4)”; and

18 (ii) in paragraph (4)—

1 (I) in the heading, by inserting

2 “AND ENDING WITH 2013” after

3 “YEARS BEGINNING WITH 2001”; and

4 (II) in subparagraph (A), by in-

5 serting “and ending with 2013” after

6 “a year beginning with 2001”; and

7 (B) in subsection (f)—

8 (i) in paragraph (1)(B), by inserting

9 “through 2013” after “of each succeeding  
10 year”; and

11 (ii) in paragraph (2), in the matter

12 preceding subparagraph (A), by inserting

13 “and ending with 2013” after “beginning  
14 with 2000”.

15 (2) UPDATE OF RATES FOR APRIL THROUGH

16 DECEMBER OF 2014, 2015, AND SUBSEQUENT

17 YEARS.—Subsection (d) of section 1848 of the Social

18 Security Act (42 U.S.C. 1395w–4) is amended by

19 striking paragraph (15) and inserting the following

20 new paragraphs:

21 “(15) UPDATE FOR 2014 THROUGH 2018.—The

22 update to the single conversion factor established in

23 paragraph (1)(C) for 2014 and each subsequent

24 year through 2018 shall be 0.5 percent.

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

5           “(17) UPDATE FOR 2024 AND SUBSEQUENT  
 6           YEARS.—The update to the single conversion factor  
 7           established in paragraph (1)(C) for 2024 and each  
 8           subsequent year shall be—

9                   “(A) for items and services furnished by a  
 10                  qualifying APM participant (as defined in sec-  
 11                  tion 1833(z)(2)) for such year, 1.0 percent; and

12                   “(B) for other items and services, 0.5 per-  
 13                  cent.”.

14           (3) MEDPAC REPORTS.—

15                   (A) INITIAL REPORT.—Not later than July  
 16                  1, 2016, the Medicare Payment Advisory Com-  
 17                  mission shall submit to Congress a report on  
 18                  the relationship between—

19                           (i) physician and other health profes-  
 20                           sional utilization and expenditures (and the  
 21                           rate of increase of such utilization and ex-  
 22                           penditures) of items and services for which  
 23                           payment is made under section 1848 of the  
 24                           Social Security Act (42 U.S.C. 1395w–4);  
 25                           and

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

5 Such report shall include a methodology to de-  
6 scribe such relationship and the impact of  
7 changes in such physician and other health pro-  
8 fessional practice and service ordering patterns  
9 on total utilization and expenditures under  
10 parts A, B, and D of such title.

11 (B) FINAL REPORT.—Not later than July  
12 1, 2020, the Medicare Payment Advisory Com-  
13 mission shall submit to Congress a report on  
14 the relationship described in subparagraph (A),  
15 including the results determined from applying  
16 the methodology included in the report sub-  
17 mitted under such subparagraph.

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

23 (i) the payment update for profes-  
24 sional services applied under the Medicare  
25 program under title XVIII of the Social

1 Security Act for the period of years 2014  
2 through 2018;

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

6 (iii) the effect of such update on en-  
7 suring a sufficient number of providers to  
8 maintain access to care by Medicare bene-  
9 ficiaries; and

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

15 (b) CONSOLIDATION OF CERTAIN CURRENT LAW  
16 PERFORMANCE PROGRAMS WITH NEW MERIT-BASED IN-  
17 CENTIVE PAYMENT SYSTEM.—

18 (1) EHR MEANINGFUL USE INCENTIVE PRO-  
19 GRAM.—

20 (A) SUNSETTING SEPARATE MEANINGFUL  
21 USE PAYMENT ADJUSTMENTS.—Section  
22 1848(a)(7)(A) of the Social Security Act (42  
23 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”;

(III) in subclause (II), by striking “; and” and inserting a period; and

(IV) by striking subclause (III); and

(iii) by striking clause (iii).

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

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

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

1 (II) by inserting “, or pursuant  
2 to subparagraph (D) for purposes of  
3 subsection (q), for a performance pe-  
4 riod under such subsection for a year”  
5 after “under such subsection for a  
6 year”; and

7 (ii) by adding at the end the following  
8 new subparagraph:

9 “(D) CONTINUED APPLICATION FOR PUR-  
10 POSES OF MIPS.—With respect to 2018 and  
11 each subsequent payment year, the Secretary  
12 shall, for purposes of subsection (q) and in ac-  
13 cordance with paragraph (1)(F) of such sub-  
14 section, determine whether an eligible profes-  
15 sional who is a MIPS eligible professional (as  
16 defined in subsection (q)(1)(C)) for such year is  
17 a meaningful EHR user under this paragraph  
18 for the performance period under subsection (q)  
19 for such year.”.

20 (2) QUALITY REPORTING.—

21 (A) SUNSETTING SEPARATE QUALITY RE-  
22 PORTING INCENTIVES.—Section 1848(a)(8)(A)  
23 of the Social Security Act (42 U.S.C. 1395w-  
24 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:

“(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

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

“(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.”; and

(ii) in subsection (m)—

(I) by redesignating paragraph (7) added by section 10327(a) of Public Law 111-148 as paragraph (8); and

1 (II) by adding at the end the fol-  
 2 lowing new paragraph:

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

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

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

12 (3) VALUE-BASED PAYMENTS.—

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

18 “(iii) APPLICATION.—The Secretary  
 19 shall apply the payment modifier estab-  
 20 lished under this subsection for items and  
 21 services furnished on or after January 1,  
 22 2015, but before January 1, 2018, with re-  
 23 spect to specific physicians and groups of  
 24 physicians the Secretary determines appro-  
 25 priate. Such payment modifier shall not be

1 applied for items and services furnished on  
 2 or after January 1, 2018.”.

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

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

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

14 (ii) in paragraph (3), by adding at the  
 15 end the following: “With respect to 2018  
 16 and each subsequent year, the Secretary  
 17 shall, in accordance with subsection  
 18 (q)(1)(F), carry out this paragraph for  
 19 purposes of subsection (q).”.

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

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

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

25 “(1) ESTABLISHMENT.—

1           “(A) IN GENERAL.—Subject to the suc-  
2           ceeding provisions of this subsection, the Sec-  
3           retary shall establish an eligible professional  
4           Merit-based Incentive Payment System (in this  
5           subsection referred to as the ‘MIPS’) under  
6           which the Secretary shall—

7                   “(i) develop a methodology for assess-  
8                   ing the total performance of each MIPS el-  
9                   igible professional according to perform-  
10                  ance standards under paragraph (3) for a  
11                  performance period (as established under  
12                  paragraph (4)) for a year;

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

18                  “(iii) use such composite performance  
19                  score of the MIPS eligible professional for  
20                  a performance period for a year to deter-  
21                  mine and apply a MIPS adjustment factor  
22                  (and, as applicable, an additional MIPS  
23                  adjustment factor) under paragraph (6) to  
24                  the professional for the year.

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

4           “(C) MIPS ELIGIBLE PROFESSIONAL DE-  
5 FINED.—

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

10           “(I) for the first and second  
11 years for which the MIPS applies to  
12 payments (and for the performance  
13 period for such first and second year),  
14 a physician (as defined in section  
15 1861(r)), a physician assistant, nurse  
16 practitioner, and clinical nurse spe-  
17 cialist (as such terms are defined in  
18 section 1861(aa)(5)), and a certified  
19 registered nurse anesthetist (as de-  
20 fined in section 1861(bb)(2)) and a  
21 group that includes such profes-  
22 sionals; and

23           “(II) for the third year for which  
24 the MIPS applies to payments (and  
25 for the performance period for such

1 third year) and for each succeeding  
2 year (and for the performance period  
3 for each such year), the professionals  
4 described in subclause (I) and such  
5 other eligible professionals (as defined  
6 in subsection (k)(3)(B)) as specified  
7 by the Secretary and a group that in-  
8 cludes such professionals.

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

14 “(I) is a qualifying APM partici-  
15 pant (as defined in section  
16 1833(z)(2));

17 “(II) subject to clause (vii), is a  
18 partial qualifying APM participant (as  
19 defined in clause (iii)) for the most re-  
20 cent period for which data are avail-  
21 able and who, for the performance pe-  
22 riod with respect to such year, does  
23 not report on applicable measures and  
24 activities described in paragraph  
25 (2)(B) that are required to be re-

1                   ported by such a professional under  
2                   the MIPS; or

3                   “(III) for the performance period  
4                   with respect to such year, does not ex-  
5                   ceed the low-volume threshold meas-  
6                   urement selected under clause (iv).

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

19                  “(I) with respect to 2018 and  
20                  2019, the reference in subparagraph  
21                  (A) of such paragraph to 25 percent  
22                  was instead a reference to 20 percent;

23                  “(II) with respect to 2020 and  
24                  2021—

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

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

11 “(III) with respect to 2022 and  
12 subsequent years—

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

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

23 “(iv) SELECTION OF LOW-VOLUME  
24 THRESHOLD MEASUREMENT.—The Sec-  
25 retary shall select a low-volume threshold



1 to apply for purposes of clause (ii)(III),  
2 which may include one or more or a com-  
3 bination of the following:

4 “(I) The minimum number (as  
5 determined by the Secretary) of indi-  
6 viduals enrolled under this part who  
7 are treated by the eligible professional  
8 for the performance period involved.

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

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

19 “(v) TREATMENT OF NEW MEDICARE  
20 ENROLLED ELIGIBLE PROFESSIONALS.—In  
21 the case of a professional who first be-  
22 comes a Medicare enrolled eligible profes-  
23 sional during the performance period for a  
24 year (and had not previously submitted  
25 claims under this title such as a person, an

1 entity, or a part of a physician group or  
2 under a different billing number or tax  
3 identifier), such professional shall not be  
4 treated under this subsection as a MIPS  
5 eligible professional until the subsequent  
6 year and performance period for such sub-  
7 sequent year.

8 “(vi) CLARIFICATION.—In the case of  
9 items and services furnished during a year  
10 by an individual who is not a MIPS eligible  
11 professional (including pursuant to clauses  
12 (ii) and (v)) with respect to a year, in no  
13 case shall a MIPS adjustment factor (or  
14 additional MIPS adjustment factor) under  
15 paragraph (6) apply to such individual for  
16 such year.

17 “(vii) PARTIAL QUALIFYING APM PAR-  
18 TICIPANT CLARIFICATIONS.—

19 “(I) TREATMENT AS MIPS ELIGI-  
20 BLE PROFESSIONAL.—In the case of  
21 an eligible professional who is a par-  
22 tial qualifying APM participant, with  
23 respect to a year, and who for the  
24 performance period for such year re-  
25 ports on applicable measures and ac-

1           activities described in paragraph (2)(B)  
 2           that are required to be reported by  
 3           such a professional under the MIPS,  
 4           such eligible professional is considered  
 5           to be a MIPS eligible professional  
 6           with respect to such year.

7                   “(II) NOT ELIGIBLE FOR QUALI-  
 8           FYING    APM    PARTICIPANT    PAY-  
 9           MENTS.—In no case shall an eligible  
 10          professional who is a partial quali-  
 11          fying APM participant, with respect  
 12          to a year, be considered a qualifying  
 13          APM participant (as defined in para-  
 14          graph (2) of section 1833(z)) for such  
 15          year or be eligible for the additional  
 16          payment under paragraph (1) of such  
 17          section for such year.

18                   “(D) APPLICATION TO GROUP PRAC-  
 19          TICES.—

20                   “(i) IN GENERAL.—Under the MIPS:

21                           “(I) QUALITY PERFORMANCE  
 22          CATEGORY.—The Secretary shall es-  
 23          tablish and apply a process that in-  
 24          cludes features of the provisions of  
 25          subsection (m)(3)(C) for MIPS eligi-

1 ble professionals in a group practice  
2 with respect to assessing performance  
3 of such group with respect to the per-  
4 formance category described in clause  
5 (i) of paragraph (2)(A).

6 “(II) OTHER PERFORMANCE CAT-  
7 EGORIES.—The Secretary may estab-  
8 lish and apply a process that includes  
9 features of the provisions of sub-  
10 section (m)(3)(C) for MIPS eligible  
11 professionals in a group practice with  
12 respect to assessing the performance  
13 of such group with respect to the per-  
14 formance categories described in  
15 clauses (ii) through (iv) of such para-  
16 graph.

17 “(ii) ENSURING COMPREHENSIVENESS  
18 OF GROUP PRACTICE ASSESSMENT.—The  
19 process established under clause (i) shall to  
20 the extent practicable reflect the range of  
21 items and services furnished by the MIPS  
22 eligible professionals in the group practice  
23 involved.

24 “(iii) CLARIFICATION.—MIPS eligible  
25 professionals electing to be a virtual group

1 under paragraph (5)(I) shall not be consid-  
2 ered MIPS eligible professionals in a group  
3 practice for purposes of applying this sub-  
4 paragraph.

5 “(E) USE OF REGISTRIES.—Under the  
6 MIPS, the Secretary shall encourage the use of  
7 qualified clinical data registries pursuant to  
8 subsection (m)(3)(E) in carrying out this sub-  
9 section.

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

14 “(i) adjust the application of such  
15 provision to ensure the provision is con-  
16 sistent with the provisions of this sub-  
17 section; and

18 “(ii) not apply such provision to the  
19 extent that the provision is duplicative with  
20 a provision of this subsection.

21 “(G) ACCOUNTING FOR RISK FACTORS.—

22 “(i) RISK FACTORS.—Taking into ac-  
23 count the relevant studies conducted and  
24 recommendations made in reports under  
25 section 2(f)(1) of the SGR Repeal and

1 Medicare Provider Payment Modernization  
2 Act of 2014, the Secretary, on an ongoing  
3 basis, shall estimate how an individual's  
4 health status and other risk factors affect  
5 quality and resource use outcome measures  
6 and, as feasible, shall incorporate informa-  
7 tion from quality and resource use outcome  
8 measurement (including care episode and  
9 patient condition groups) into the MIPS.

10 “(ii) ACCOUNTING FOR OTHER FAC-  
11 TORS IN PAYMENT ADJUSTMENTS.—Tak-  
12 ing into account the 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 and other information as ap-  
17 propriate, the Secretary shall account for  
18 identified factors with an effect on quality  
19 and resource use outcome measures when  
20 determining payment adjustments, com-  
21 posite performance scores, scores for per-  
22 formance categories, or scores for meas-  
23 ures or activities under the MIPS.

24 “(2) MEASURES AND ACTIVITIES UNDER PER-  
25 FORMANCE CATEGORIES.—

1           “(A) PERFORMANCE CATEGORIES.—Under  
2           the MIPS, the Secretary shall use the following  
3           performance categories (each of which is re-  
4           ferred to in this subsection as a performance  
5           category) in determining the composite per-  
6           formance score under paragraph (5):

7                   “(i) Quality.

8                   “(ii) Resource use.

9                   “(iii) Clinical practice improvement  
10           activities.

11                   “(iv) Meaningful use of certified EHR  
12           technology.

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

19                   “(i) QUALITY.—For the performance  
20           category described in subparagraph (A)(i),  
21           the quality measures included in the final  
22           measures list published under subpara-  
23           graph (D)(i) for such year and the list of  
24           quality measures described in subpara-

graph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

“(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

“(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

“(I) The subcategory of expanded practice access, which shall include activities such as same day appointments for urgent needs and after hours access to clinician advice.

“(II) The subcategory of population management, which shall in-



1 include activities such as monitoring  
2 health conditions of individuals to pro-  
3 vide timely health care interventions  
4 or participation in a qualified clinical  
5 data registry.

6 “(III) The subcategory of care  
7 coordination, which shall include ac-  
8 tivities such as timely communication  
9 of test results, timely exchange of  
10 clinical information to patients and  
11 other providers, and use of remote  
12 monitoring or telehealth.

13 “(IV) The subcategory of bene-  
14 ficiary engagement, which shall in-  
15 clude activities such as the establish-  
16 ment of care plans for individuals  
17 with complex care needs, beneficiary  
18 self-management assessment and  
19 training, and using shared decision-  
20 making mechanisms.

21 “(V) The subcategory of patient  
22 safety and practice assessment, such  
23 as through use of clinical or surgical  
24 checklists and practice assessments  
25 related to maintaining certification.

1 “(VI) The subcategory of partici-  
2 pation in an alternative payment  
3 model (as defined in section  
4 1833(z)(3)(C)).

5 In establishing activities under this clause,  
6 the Secretary shall give consideration to  
7 the circumstances of small practices (con-  
8 sisting of 15 or fewer professionals) and  
9 practices located in rural areas and in  
10 health professional shortage areas (as des-  
11 ignated under section 332(a)(1)(A) of the  
12 Public Health Service Act).

13 “(iv) MEANINGFUL EHR USE.—For  
14 the performance category described in sub-  
15 paragraph (A)(iv), the requirements estab-  
16 lished for such period under subsection  
17 (o)(2) for determining whether an eligible  
18 professional is a meaningful EHR user.

19 “(C) ADDITIONAL PROVISIONS.—

20 “(i) EMPHASIZING OUTCOME MEAS-  
21 URES UNDER THE QUALITY PERFORMANCE  
22 CATEGORY.—In applying subparagraph  
23 (B)(i), the Secretary shall, as feasible, em-  
24 phasize the application of outcome meas-  
25 ures.

1           “(ii) APPLICATION OF ADDITIONAL  
2           SYSTEM MEASURES.—The Secretary may  
3           use measures used for a payment system  
4           other than for physicians, such as meas-  
5           ures for inpatient hospitals, for purposes of  
6           the performance categories described in  
7           clauses (i) and (ii) of subparagraph (A).  
8           For purposes of the previous sentence, the  
9           Secretary may not use measures for hos-  
10          pital outpatient departments, except in the  
11          case of emergency physicians.

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

18          “(iv) APPLICATION OF MEASURES AND  
19          ACTIVITIES TO NON-PATIENT-FACING PRO-  
20          FESSIONALS.—In carrying out this para-  
21          graph, with respect to measures and activi-  
22          ties specified in subparagraph (B) for per-  
23          formance categories described in subpara-  
24          graph (A), the Secretary—

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

8                   “(II) may, to the extent feasible  
9                   and appropriate, take into account  
10                  such circumstances and apply under  
11                  this subsection with respect to MIPS  
12                  eligible professionals of such profes-  
13                  sional types or subcategories, alter-  
14                  native measures or activities that ful-  
15                  fill the goals of the applicable per-  
16                  formance category.

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

20                  “(v) CLINICAL PRACTICE IMPROVE-  
21                  MENT ACTIVITIES.—

22                  “(I) REQUEST FOR INFORMA-  
23                  TION.—In initially applying subpara-  
24                  graph (B)(iii), the Secretary shall use  
25                  a request for information to solicit

1 recommendations from stakeholders to  
2 identify activities described in such  
3 subparagraph and specifying criteria  
4 for such activities.

5 “(II) CONTRACT AUTHORITY FOR  
6 CLINICAL PRACTICE IMPROVEMENT  
7 ACTIVITIES PERFORMANCE CAT-  
8 EGORY.—In applying subparagraph  
9 (B)(iii), the Secretary may contract  
10 with entities to assist the Secretary  
11 in—

12 “(aa) identifying activities  
13 described in subparagraph  
14 (B)(iii);

15 “(bb) specifying criteria for  
16 such activities; and

17 “(cc) determining whether a  
18 MIPS eligible professional meets  
19 such criteria.

20 “(III) CLINICAL PRACTICE IM-  
21 PROVEMENT ACTIVITIES DEFINED.—  
22 For purposes of this subsection, the  
23 term ‘clinical practice improvement  
24 activity’ means an activity that rel-  
25 evant eligible professional organiza-

1           tions and other relevant stakeholders  
2           identify as improving clinical practice  
3           or care delivery and that the Sec-  
4           retary determines, when effectively ex-  
5           ecuted, is likely to result in improved  
6           outcomes.

7           “(D) ANNUAL LIST OF QUALITY MEASURES  
8           AVAILABLE FOR MIPS ASSESSMENT.—

9           “(i) IN GENERAL.—Under the MIPS,  
10          the Secretary, through notice and comment  
11          rulemaking and subject to the succeeding  
12          clauses of this subparagraph, shall, with  
13          respect to the performance period for a  
14          year, establish an annual final list of qual-  
15          ity measures from which MIPS eligible  
16          professionals may choose for purposes of  
17          assessment under this subsection for such  
18          performance period. Pursuant to the pre-  
19          vious sentence, the Secretary shall—

20          “(I) not later than November 1  
21          of the year prior to the first day of  
22          the first performance period under the  
23          MIPS, establish and publish in the  
24          Federal Register a final list of quality  
25          measures; and

1 “(II) not later than November 1  
2 of the year prior to the first day of  
3 each subsequent performance period,  
4 update the final list of quality meas-  
5 ures from the previous year (and pub-  
6 lish such updated final list in the Fed-  
7 eral Register), by—

8 “(aa) removing from such  
9 list, as appropriate, quality meas-  
10 ures, which may include the re-  
11 moval of measures that are no  
12 longer meaningful (such as meas-  
13 ures that are topped out);

14 “(bb) adding to such list, as  
15 appropriate, new quality meas-  
16 ures; and

17 “(cc) determining whether  
18 or not quality measures on such  
19 list that have undergone sub-  
20 stantive changes should be in-  
21 cluded in the updated list.

22 “(ii) CALL FOR QUALITY MEAS-  
23 URES.—

24 “(I) IN GENERAL.—Eligible pro-  
25 fessional organizations and other rel-

1           evant stakeholders shall be requested  
2           to identify and submit quality meas-  
3           ures to be considered for selection  
4           under this subparagraph in the an-  
5           nual list of quality measures published  
6           under clause (i) and to identify and  
7           submit updates to the measures on  
8           such list. For purposes of the previous  
9           sentence, measures may be submitted  
10          regardless of whether such measures  
11          were previously published in a pro-  
12          posed rule or endorsed by an entity  
13          with a contract under section 1890(a).

14                   “(II) ELIGIBLE PROFESSIONAL  
15                   ORGANIZATION DEFINED.—In this  
16                   subparagraph, the term ‘eligible pro-  
17                   fessional organization’ means a pro-  
18                   fessional organization as defined by  
19                   nationally recognized multispecialty  
20                   boards of certification or equivalent  
21                   certification boards.

22                   “(iii) REQUIREMENTS.—In selecting  
23                   quality measures for inclusion in the an-  
24                   nual final list under clause (i), the Sec-  
25                   retary shall—



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

5                   “(II) ensure that such selection  
6                   is consistent with the process for se-  
7                   lection of measures under subsections  
8                   (k), (m), and (p)(2).

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

19                  “(v) MEASURES FOR INCLUSION.—  
20                  The final list of quality measures published  
21                  under clause (i) shall include, as applica-  
22                  ble, measures under subsections (k), (m),  
23                  and (p)(2), including quality measures  
24                  from among—

- 1 “(I) measures endorsed by a con-  
2 sensus-based entity;  
3 “(II) measures developed under  
4 subsection (s); and  
5 “(III) measures submitted under  
6 clause (ii)(I).

7 Any measure selected for inclusion in such  
8 list that is not endorsed by a consensus-  
9 based entity shall have a focus that is evi-  
10 dence-based.

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

21 “(vii) EXCEPTION FOR EXISTING  
22 QUALITY MEASURES.—Any quality meas-  
23 ure specified by the Secretary under sub-  
24 section (k) or (m), including under sub-  
25 section (m)(3)(E), and any measure of

1           quality of care established under sub-  
2           section (p)(2) for the reporting period  
3           under the respective subsection beginning  
4           before the first performance period under  
5           the MIPS—

6                     “(I) shall not be subject to the  
7                     requirements under clause (i) (except  
8                     under items (aa) and (cc) of subclause  
9                     (II) of such clause) or to the require-  
10                    ment under clause (iv); and

11                   “(II) shall be included in the  
12                   final list of quality measures pub-  
13                   lished under clause (i) unless removed  
14                   under clause (i)(II)(aa).

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

23                   “(ix) OPTIONAL APPLICATION.—The  
24                   process under section 1890A is not re-

1           quired to apply to the selection of meas-  
2           ures under this subparagraph.

3           “(3) PERFORMANCE STANDARDS.—

4           “(A) ESTABLISHMENT.—Under the MIPS,  
5           the Secretary shall establish performance stand-  
6           ards with respect to measures and activities  
7           specified under paragraph (2)(B) for a perform-  
8           ance period (as established under paragraph  
9           (4)) for a year.

10           “(B) CONSIDERATIONS IN ESTABLISHING  
11           STANDARDS.—In establishing such performance  
12           standards with respect to measures and activi-  
13           ties specified under paragraph (2)(B), the Sec-  
14           retary shall consider the following:

15                   “(i) Historical performance standards.

16                   “(ii) Improvement.

17                   “(iii) The opportunity for continued  
18           improvement.

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

1 a year shall be referred to as the performance period  
2 for the year.

3 “(5) COMPOSITE PERFORMANCE SCORE.—

4 “(A) IN GENERAL.—Subject to the suc-  
5 ceeding provisions of this paragraph and taking  
6 into account, as available and applicable, para-  
7 graph (1)(G), the Secretary shall develop a  
8 methodology for assessing the total performance  
9 of each MIPS eligible professional according to  
10 performance standards under paragraph (3)  
11 with respect to applicable measures and activi-  
12 ties specified in paragraph (2)(B) with respect  
13 to each performance category applicable to such  
14 professional for a performance period (as estab-  
15 lished under paragraph (4)) for a year. Using  
16 such methodology, the Secretary shall provide  
17 for a composite assessment (using a scoring  
18 scale of 0 to 100) for each such professional for  
19 the performance period for such year. In this  
20 subsection such a composite assessment for  
21 such a professional with respect to a perform-  
22 ance period shall be referred to as the ‘com-  
23 posite performance score’ for such professional  
24 for such performance period.

1           “(B) INCENTIVE TO REPORT; ENCOUR-  
2           AGING USE OF CERTIFIED EHR TECHNOLOGY  
3           FOR REPORTING QUALITY MEASURES.—

4           “(i) INCENTIVE TO REPORT.—Under  
5           the methodology established under sub-  
6           paragraph (A), the Secretary shall provide  
7           that in the case of a MIPS eligible profes-  
8           sional who fails to report on an applicable  
9           measure or activity that is required to be  
10          reported by the professional, the profes-  
11          sional shall be treated as achieving the  
12          lowest potential score applicable to such  
13          measure or activity.

14          “(ii) ENCOURAGING USE OF CER-  
15          TIFIED EHR TECHNOLOGY AND QUALIFIED  
16          CLINICAL DATA REGISTRIES FOR REPORT-  
17          ING QUALITY MEASURES.—Under the  
18          methodology established under subpara-  
19          graph (A), the Secretary shall—

20               “(I) encourage MIPS eligible  
21               professionals to report on applicable  
22               measures with respect to the perform-  
23               ance category described in paragraph  
24               (2)(A)(i) through the use of certified

1 EHR technology and qualified clinical  
2 data registries; and

3 “(II) with respect to a perform-  
4 ance period, with respect to a year,  
5 for which a MIPS eligible professional  
6 reports such measures through the  
7 use of such EHR technology, treat  
8 such professional as satisfying the  
9 clinical quality measures reporting re-  
10 quirement described in subsection  
11 (o)(2)(A)(iii) for such year.

12 “(C) CLINICAL PRACTICE IMPROVEMENT  
13 ACTIVITIES PERFORMANCE SCORE.—

14 “(i) RULE FOR ACCREDITATION.—A  
15 MIPS eligible professional who is in a  
16 practice that is certified as a patient-cen-  
17 tered medical home or comparable spe-  
18 cialty practice pursuant to subsection  
19 (b)(8)(B)(i) with respect to a performance  
20 period shall be given the highest potential  
21 score for the performance category de-  
22 scribed in paragraph (2)(A)(iii) for such  
23 period.

24 “(ii) APM PARTICIPATION.—Partici-  
25 pation by a MIPS eligible professional in

1 an alternative payment model (as defined  
2 in section 1833(z)(3)(C)) with respect to a  
3 performance period shall earn such eligible  
4 professional a minimum score of one-half  
5 of the highest potential score for the per-  
6 formance category described in paragraph  
7 (2)(A)(iii) for such performance period.

8 “(iii) SUBCATEGORIES.—A MIPS eli-  
9 gible professional shall not be required to  
10 perform activities in each subcategory  
11 under paragraph (2)(B)(iii) or participate  
12 in an alternative payment model in order  
13 to achieve the highest potential score for  
14 the performance category described in  
15 paragraph (2)(A)(iii).

16 “(D) ACHIEVEMENT AND IMPROVE-  
17 MENT.—

18 “(i) TAKING INTO ACCOUNT IMPROVE-  
19 MENT.—Beginning with the second year to  
20 which the MIPS applies, in addition to the  
21 achievement of a MIPS eligible profes-  
22 sional, if data sufficient to measure im-  
23 provement is available, the methodology  
24 developed under subparagraph (A)—



1                   “(I) in the case of the perform-  
2                   ance score for the performance cat-  
3                   egory described in clauses (i) and (ii)  
4                   of paragraph (2)(A), shall take into  
5                   account the improvement of the pro-  
6                   fessional; and

7                   “(II) in the case of performance  
8                   scores for other performance cat-  
9                   egories, may take into account the im-  
10                  provement of the professional.

11                  “(ii) ASSIGNING HIGHER WEIGHT FOR  
12                  ACHIEVEMENT.—Beginning with the  
13                  fourth year to which the MIPS applies,  
14                  under the methodology developed under  
15                  subparagraph (A), the Secretary may as-  
16                  sign a higher scoring weight under sub-  
17                  paragraph (F) with respect to the achieve-  
18                  ment of a MIPS eligible professional than  
19                  with respect to any improvement of such  
20                  professional applied under clause (i) with  
21                  respect to a measure, activity, or category  
22                  described in paragraph (2).

23                  “(E) WEIGHTS FOR THE PERFORMANCE  
24                  CATEGORIES.—

1 “(i) IN GENERAL.—Under the meth-  
2 odology developed under subparagraph (A),  
3 subject to subparagraph (F)(i) and clauses  
4 (ii) and (iii), the composite performance  
5 score shall be determined as follows:

6 “(I) QUALITY.—

7 “(aa) IN GENERAL.—Sub-  
8 ject to item (bb), thirty percent  
9 of such score shall be based on  
10 performance with respect to the  
11 category described in clause (i) of  
12 paragraph (2)(A). In applying  
13 the previous sentence, the Sec-  
14 retary shall, as feasible, encour-  
15 age the application of outcome  
16 measures within such category.

17 “(bb) FIRST 2 YEARS.—For  
18 the first and second years for  
19 which the MIPS applies to pay-  
20 ments, the percentage applicable  
21 under item (aa) shall be in-  
22 creased in a manner such that  
23 the total percentage points of the  
24 increase under this item for the  
25 respective year equals the total

1 number of percentage points by  
2 which the percentage applied  
3 under subclause (II)(bb) for the  
4 respective year is less than 30  
5 percent.

6 “(II) RESOURCE USE.—

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

13 “(bb) FIRST 2 YEARS.—For  
14 the first year for which the MIPS  
15 applies to payments, not more  
16 than 10 percent of such score  
17 shall be based on performance  
18 with respect to the category de-  
19 scribed in clause (ii) of para-  
20 graph (2)(A). For the second  
21 year for which the MIPS applies  
22 to payments, not more than 15  
23 percent of such score shall be  
24 based on performance with re-

spect to the category described in clause (ii) of paragraph (2)(A).

“(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

“(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

“(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such re-

1           duction for a year, subject to subclauses  
2           (I)(bb) and (II)(bb) of clause (i), the per-  
3           centages applicable under one or more of  
4           subclauses (I), (II), and (III) of clause (i)  
5           for such year shall be increased in a man-  
6           ner such that the total percentage points  
7           of the increase under this clause for such  
8           year equals the total number of percentage  
9           points reduced under the preceding sen-  
10          tence for such year.

11           “(F)     CERTAIN     FLEXIBILITY     FOR  
12          WEIGHTING PERFORMANCE CATEGORIES, MEAS-  
13          URES, AND ACTIVITIES.—Under the method-  
14          ology under subparagraph (A), if there are not  
15          sufficient measures and clinical practice im-  
16          provement activities applicable and available to  
17          each type of eligible professional involved, the  
18          Secretary shall assign different scoring weights  
19          (including a weight of 0)—

20                 “(i) which may vary from the scoring  
21                 weights specified in subparagraph (E), for  
22                 each performance category based on the  
23                 extent to which the category is applicable  
24                 to the type of eligible professional involved;  
25                 and

1                   “(ii) for each measure and activity  
2                   specified under paragraph (2)(B) with re-  
3                   spect to each such category based on the  
4                   extent to which the measure or activity is  
5                   applicable and available to the type of eli-  
6                   gible professional involved.

7                   “(G) RESOURCE USE.—Analysis of the  
8                   performance category described in paragraph  
9                   (2)(A)(ii) shall include results from the method-  
10                  ology described in subsection (r)(5), as appro-  
11                  priate.

12                  “(H) INCLUSION OF QUALITY MEASURE  
13                  DATA FROM OTHER PAYERS.—In applying sub-  
14                  sections (k), (m), and (p) with respect to meas-  
15                  ures described in paragraph (2)(B)(i), analysis  
16                  of the performance category described in para-  
17                  graph (2)(A)(i) may include data submitted by  
18                  MIPS eligible professionals with respect to  
19                  items and services furnished to individuals who  
20                  are not individuals entitled to benefits under  
21                  part A or enrolled under part B.

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

24                  “(i) IN GENERAL.—In the case of  
25                  MIPS eligible professionals electing to be a

1 virtual group under clause (ii) with respect  
2 to a performance period for a year, for  
3 purposes of applying the methodology  
4 under subparagraph (A)—

5 “(I) the assessment of perform-  
6 ance provided under such methodology  
7 with respect to the performance cat-  
8 egories described in clauses (i) and  
9 (ii) of paragraph (2)(A) that is to be  
10 applied to each such professional in  
11 such group for such performance pe-  
12 riod shall be with respect to the com-  
13 bined performance of all such profes-  
14 sionals in such group for such period;  
15 and

16 “(II) the composite score pro-  
17 vided under this paragraph for such  
18 performance period with respect to  
19 each such performance category for  
20 each such MIPS eligible professional  
21 in such virtual group shall be based  
22 on the assessment of the combined  
23 performance under subclause (I) for  
24 the performance category and per-  
25 formance period.

1                   “(ii) ELECTION OF PRACTICES TO BE  
2                   A VIRTUAL GROUP.—The Secretary shall,  
3                   in accordance with clause (iii), establish  
4                   and have in place a process to allow an in-  
5                   dividual MIPS eligible professional or a  
6                   group practice consisting of not more than  
7                   10 MIPS eligible professionals to elect,  
8                   with respect to a performance period for a  
9                   year, for such individual MIPS eligible pro-  
10                  fessional or all such MIPS eligible profes-  
11                  sionals in such group practice, respectively,  
12                  to be a virtual group under this subpara-  
13                  graph with at least one other such indi-  
14                  vidual MIPS eligible professional or group  
15                  practice making such an election. Such a  
16                  virtual group may be based on geographic  
17                  areas or on provider specialties defined by  
18                  nationally recognized multispecialty boards  
19                  of certification or equivalent certification  
20                  boards and such other eligible professional  
21                  groupings in order to capture classifica-  
22                  tions of providers across eligible profes-  
23                  sional organizations and other practice  
24                  areas or categories.



1 “(iii) REQUIREMENTS.—The process  
2 under clause (ii)—

3 “(I) shall provide that an election  
4 under such clause, with respect to a  
5 performance period, shall be made be-  
6 fore or during the beginning of such  
7 performance period and may not be  
8 changed during such performance pe-  
9 riod;

10 “(II) shall provide that a practice  
11 described in such clause, and each  
12 MIPS eligible professional in such  
13 practice, may elect to be in no more  
14 than one virtual group for a perform-  
15 ance period; and

16 “(III) may provide that a virtual  
17 group may be combined at the tax  
18 identification number level.

19 “(6) MIPS PAYMENTS.—

20 “(A) MIPS ADJUSTMENT FACTOR.—Tak-  
21 ing into account paragraph (1)(G), the Sec-  
22 retary shall specify a MIPS adjustment factor  
23 for each MIPS eligible professional for a year.  
24 Such MIPS adjustment factor for a MIPS eligi-

1           ble professional for a year shall be in the form  
2           of a percent and shall be determined—

3                   “(i) by comparing the composite per-  
4                   formance score of the eligible professional  
5                   for such year to the performance threshold  
6                   established under subparagraph (D)(i) for  
7                   such year;

8                   “(ii) in a manner such that the ad-  
9                   justment factors specified under this sub-  
10                  paragraph for a year result in differential  
11                  payments under this paragraph reflecting  
12                  that—

13                   “(I) MIPS eligible professionals  
14                   with composite performance scores for  
15                   such year at or above such perform-  
16                   ance threshold for such year receive  
17                   zero or positive incentive payment ad-  
18                   justment factors for such year in ac-  
19                   cordance with clause (iii), with such  
20                   professionals having higher composite  
21                   performance scores receiving higher  
22                   adjustment factors; and

23                   “(II) MIPS eligible professionals  
24                   with composite performance scores for  
25                   such year below such performance

1 threshold for such year receive nega-  
2 tive payment adjustment factors for  
3 such year in accordance with clause  
4 (iv), with such professionals having  
5 lower composite performance scores  
6 receiving lower adjustment factors;

7 “(iii) in a manner such that MIPS eli-  
8 gible professionals with composite scores  
9 described in clause (ii)(I) for such year,  
10 subject to clauses (i) and (ii) of subpara-  
11 graph (F), receive a zero or positive ad-  
12 justment factor on a linear sliding scale  
13 such that an adjustment factor of 0 per-  
14 cent is assigned for a score at the perform-  
15 ance threshold and an adjustment factor of  
16 the applicable percent specified in subpara-  
17 graph (B) is assigned for a score of 100;  
18 and

19 “(iv) in a manner such that—

20 “(I) subject to subclause (II),  
21 MIPS eligible professionals with com-  
22 posite performance scores described in  
23 clause (ii)(II) for such year receive a  
24 negative payment adjustment factor  
25 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 performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

“(B) APPLICABLE PERCENT DEFINED.—

For purposes of this paragraph, the term ‘applicable percent’ means—

“(i) for 2018, 4 percent;

“(ii) for 2019, 5 percent;

“(iii) for 2020, 7 percent; and

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

1 “(C) ADDITIONAL MIPS ADJUSTMENT FAC-  
2 TORS FOR EXCEPTIONAL PERFORMANCE.—

3 “(i) IN GENERAL.—In the case of a  
4 MIPS eligible professional with a com-  
5 posite performance score for a year at or  
6 above the additional performance threshold  
7 under subparagraph (D)(ii) for such year,  
8 in addition to the MIPS adjustment factor  
9 under subparagraph (A) for the eligible  
10 professional for such year, subject to the  
11 availability of funds under clause (ii), the  
12 Secretary shall specify an additional posi-  
13 tive MIPS adjustment factor for such pro-  
14 fessional and year. Such additional MIPS  
15 adjustment factors shall be determined by  
16 the Secretary in a manner such that pro-  
17 fessionals having higher composite per-  
18 formance scores above the additional per-  
19 formance threshold receive higher addi-  
20 tional MIPS adjustment factors.

21 “(ii) ADDITIONAL FUNDING POOL.—  
22 For 2018 and each subsequent year  
23 through 2023, there is appropriated from  
24 the Federal Supplementary Medical Insur-  
25 ance Trust Fund \$500,000,000 for MIPS

1 payments under this paragraph resulting  
2 from the application of the additional  
3 MIPS adjustment factors under clause (i).

4 “(D) ESTABLISHMENT OF PERFORMANCE  
5 THRESHOLDS.—

6 “(i) PERFORMANCE THRESHOLD.—

7 For each year of the MIPS, the Secretary  
8 shall compute a performance threshold  
9 with respect to which the composite per-  
10 formance score of MIPS eligible profes-  
11 sionals shall be compared for purposes of  
12 determining adjustment factors under sub-  
13 paragraph (A) that are positive, negative,  
14 and zero. Such performance threshold for  
15 a year shall be the mean or median (as se-  
16 lected by the Secretary) of the composite  
17 performance scores for all MIPS eligible  
18 professionals with respect to a prior period  
19 specified by the Secretary. The Secretary  
20 may reassess the selection under the pre-  
21 vious sentence every 3 years.

22 “(ii) ADDITIONAL PERFORMANCE  
23 THRESHOLD FOR EXCEPTIONAL PERFORM-  
24 ANCE.—In addition to the performance  
25 threshold under clause (i), for each year of

1 the MIPS, the Secretary shall compute an  
2 additional performance threshold for pur-  
3 poses of determining the additional MIPS  
4 adjustment factors under subparagraph  
5 (C)(i). For each such year, the Secretary  
6 shall apply either of the following methods  
7 for computing such additional performance  
8 threshold for such a year:

9 “(I) The threshold shall be the  
10 score that is equal to the 25th per-  
11 centile of the range of possible com-  
12 posite performance scores above the  
13 performance threshold with respect to  
14 the prior period described in clause  
15 (i).

16 “(II) The threshold shall be the  
17 score that is equal to the 25th per-  
18 centile of the actual composite per-  
19 formance scores for MIPS eligible  
20 professionals with composite perform-  
21 ance scores at or above the perform-  
22 ance threshold with respect to the  
23 prior period described in clause (i).

24 “(iii) SPECIAL RULE FOR INITIAL 2  
25 YEARS.—With respect to each of the first

1 two years to which the MIPS applies, the  
2 Secretary shall, prior to the performance  
3 period for such years, establish a perform-  
4 ance threshold for purposes of determining  
5 MIPS adjustment factors under subpara-  
6 graph (A) and a threshold for purposes of  
7 determining additional MIPS adjustment  
8 factors under subparagraph (C)(i). Each  
9 such performance threshold shall—

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

12 “(II) take into account—

13 “(aa) data available with re-  
14 spect to performance on meas-  
15 ures and activities that may be  
16 used under the performance cat-  
17 egories under subparagraph  
18 (2)(B); and

19 “(bb) other factors deter-  
20 mined appropriate by the Sec-  
21 retary.

22 “(E) APPLICATION OF MIPS ADJUSTMENT  
23 FACTORS.—In the case of items and services  
24 furnished by a MIPS eligible professional dur-  
25 ing a year (beginning with 2018), the amount



otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

“(i) 1, plus

“(ii) the sum of—

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

“(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C)(i) divided by 100.

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

“(i) APPLICATION OF SCALING FACTOR.—

“(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment

1 factors by a scaling factor in order to  
2 ensure that the budget neutrality re-  
3 quirement of clause (ii) is met.

4 “(II) SCALING FACTOR LIMIT.—

5 In no case may be the scaling factor  
6 applied under this clause exceed 3.0.

7 “(ii) BUDGET NEUTRALITY REQUIRE-  
8 MENT.—

9 “(I) IN GENERAL.—Subject to  
10 clause (iii), the Secretary shall ensure  
11 that the estimated amount described  
12 in subclause (II) for a year is equal to  
13 the estimated amount described in  
14 subclause (III) for such year.

15 “(II) AGGREGATE INCREASES.—

16 The amount described in this sub-  
17 clause is the estimated increase in the  
18 aggregate allowed charges resulting  
19 from the application of positive MIPS  
20 adjustment factors under subpara-  
21 graph (A) (after application of the  
22 scaling factor described in clause (i))  
23 to MIPS eligible professionals whose  
24 composite performance score for a  
25 year is above the performance thresh-

old under subparagraph (D)(i) for such year.

“(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible 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.

1                   “(II) In the case that, with re-  
2                   spect to a year, the application of  
3                   clause (i) results in a scaling factor  
4                   equal to the maximum scaling factor  
5                   specified in clause (i)(II), such scaling  
6                   factor shall apply and the budget neu-  
7                   trality requirement of clause (ii) shall  
8                   not apply for such year.

9                   “(iv) ADDITIONAL INCENTIVE PAY-  
10                  MENT ADJUSTMENTS.—In specifying the  
11                  MIPS additional adjustment factors under  
12                  subparagraph (C)(i) for each applicable  
13                  MIPS eligible professional for a year, the  
14                  Secretary shall ensure that the estimated  
15                  increase in payments under this part re-  
16                  sulting from the application of such addi-  
17                  tional adjustment factors for MIPS eligible  
18                  professionals in a year shall be equal (as  
19                  estimated by the Secretary) to the addi-  
20                  tional funding pool amount for such year  
21                  under subparagraph (C)(ii).

22                  “(7) ANNOUNCEMENT OF RESULT OF ADJUST-  
23                  MENTS.—Under the MIPS, the Secretary shall, not  
24                  later than 30 days prior to January 1 of the year  
25                  involved, make available to MIPS eligible profes-

1        sionals the MIPS adjustment factor (and, as appli-  
2        cable, the additional MIPS adjustment factor) under  
3        paragraph (6) applicable to the eligible professional  
4        for items and services furnished by the professional  
5        for such year. The Secretary may include such infor-  
6        mation in the confidential feedback under paragraph  
7        (12).

8            “(8) NO EFFECT IN SUBSEQUENT YEARS.—The  
9        MIPS adjustment factors and additional MIPS ad-  
10       justment factors under paragraph (6) shall apply  
11       only with respect to the year involved, and the Sec-  
12       retary shall not take into account such adjustment  
13       factors in making payments to a MIPS eligible pro-  
14       fessional under this part in a subsequent year.

15           “(9) PUBLIC REPORTING.—

16           “(A) IN GENERAL.—The Secretary shall,  
17        in an easily understandable format, make avail-  
18        able on the Physician Compare Internet website  
19        of the Centers for Medicare & Medicaid Serv-  
20        ices the following:

21           “(i) Information regarding the per-  
22        formance of MIPS eligible professionals  
23        under the MIPS, which—

24           “(I) shall include the composite  
25        score for each such MIPS eligible pro-

1           fessional and the performance of each  
2           such MIPS eligible professional with  
3           respect to each performance category;  
4           and

5                   “(II) may include the perform-  
6           ance of each such MIPS eligible pro-  
7           fessional with respect to each measure  
8           or activity specified in paragraph  
9           (2)(B).

10                   “(ii) The names of eligible profes-  
11           sionals in eligible alternative payment mod-  
12           els (as defined in section 1833(z)(3)(D))  
13           and, to the extent feasible, the names of  
14           such eligible alternative payment models  
15           and performance of such models.

16                   “(B) DISCLOSURE.—The information  
17           made available under this paragraph shall indi-  
18           cate, where appropriate, that publicized infor-  
19           mation may not be representative of the eligible  
20           professional’s entire patient population, the va-  
21           riety of services furnished by the eligible profes-  
22           sional, or the health conditions of individuals  
23           treated.

24                   “(C) OPPORTUNITY TO REVIEW AND SUB-  
25           MIT CORRECTIONS.—The Secretary shall pro-

1           vide for an opportunity for a professional de-  
2           scribed in subparagraph (A) to review, and sub-  
3           mit corrections for, the information to be made  
4           public with respect to the professional under  
5           such subparagraph prior to such information  
6           being made public.

7           “(D)   AGGREGATE    INFORMATION.—The  
8           Secretary shall periodically post on the Physi-  
9           cian Compare Internet website aggregate infor-  
10          mation on the MIPS, including the range of  
11          composite scores for all MIPS eligible profes-  
12          sionals and the range of the performance of all  
13          MIPS eligible professionals with respect to each  
14          performance category.

15          “(10)   CONSULTATION.—The   Secretary   shall  
16          consult with stakeholders in carrying out the MIPS,  
17          including for the identification of measures and ac-  
18          tivities under paragraph (2)(B) and the methodolo-  
19          gies developed under paragraphs (5)(A) and (6) and  
20          regarding the use of qualified clinical data registries.  
21          Such consultation shall include the use of a request  
22          for information or other mechanisms determined ap-  
23          propriate.

1           “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-  
2           TICES AND PRACTICES IN HEALTH PROFESSIONAL  
3           SHORTAGE AREAS.—

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

18                   “(i) the performance categories de-  
19                  scribed in clauses (i) through (iv) of para-  
20                  graph (2)(A); or

21                   “(ii) how to transition to the imple-  
22                  mentation of and participation in an alter-  
23                  native payment model as described in sec-  
24                  tion 1833(z)(3)(C).

25                   “(B) FUNDING FOR IMPLEMENTATION.—



1 “(i) IN GENERAL.—For purposes of  
2 implementing subparagraph (A), the Sec-  
3 retary shall provide for the transfer from  
4 the Federal Supplementary Medical Insur-  
5 ance Trust Fund established under section  
6 1841 to the Centers for Medicare & Med-  
7 icaid Services Program Management Ac-  
8 count of \$40,000,000 for each of fiscal  
9 years 2015 through 2019. Amounts trans-  
10 ferred under this subparagraph for a fiscal  
11 year shall be available until expended.

12 “(ii) TECHNICAL ASSISTANCE.—Of  
13 the amounts transferred pursuant to clause  
14 (i) for each of fiscal years 2015 through  
15 2019, not less than \$10,000,000 shall be  
16 made available for each such year for tech-  
17 nical assistance to small practices in health  
18 professional shortage areas (as so des-  
19 ignated) and medically underserved areas.

20 “(12) FEEDBACK AND INFORMATION TO IM-  
21 PROVE PERFORMANCE.—

22 “(A) PERFORMANCE FEEDBACK.—

23 “(i) IN GENERAL.—Beginning July 1,  
24 2016, the Secretary—

1                   “(I) shall make available timely  
2                   (such as quarterly) confidential feed-  
3                   back to MIPS eligible professionals on  
4                   the performance of such professionals  
5                   with respect to the performance cat-  
6                   egories under clauses (i) and (ii) of  
7                   paragraph (2)(A); and

8                   “(II) may make available con-  
9                   fidential feedback to each such profes-  
10                  sional on the performance of such  
11                  professional with respect to the per-  
12                  formance categories under clauses (iii)  
13                  and (iv) of such paragraph.

14               “(ii) MECHANISMS.—The Secretary  
15               may use one or more mechanisms to make  
16               feedback available under clause (i), which  
17               may include use of a web-based portal or  
18               other mechanisms determined appropriate  
19               by the Secretary. With respect to the per-  
20               formance category described in paragraph  
21               (2)(A)(i), feedback under this subpara-  
22               graph shall, to the extent an eligible pro-  
23               fessional chooses to participate in a data  
24               registry for purposes of this subsection (in-  
25               cluding registries under subsections (k)

1 and (m)), be provided based on perform-  
2 ance on quality measures reported through  
3 the use of such registries. With respect to  
4 any other performance category described  
5 in paragraph (2)(A), the Secretary shall  
6 encourage provision of feedback through  
7 qualified clinical data registries as de-  
8 scribed in subsection (m)(3)(E)).

9 “(iii) USE OF DATA.—For purposes of  
10 clause (i), the Secretary may use data,  
11 with respect to a MIPS eligible profes-  
12 sional, from periods prior to the current  
13 performance period and may use rolling  
14 periods in order to make illustrative cal-  
15 culations about the performance of such  
16 professional.

17 “(iv) DISCLOSURE EXEMPTION.—  
18 Feedback made available under this sub-  
19 paragraph shall be exempt from disclosure  
20 under section 552 of title 5, United States  
21 Code.

22 “(v) RECEIPT OF INFORMATION.—  
23 The Secretary may use the mechanisms es-  
24 tablished under clause (ii) to receive infor-

1           mation from professionals, such as infor-  
2           mation with respect to this subsection.

3           “(B) ADDITIONAL INFORMATION.—

4                   “(i) IN GENERAL.—Beginning July 1,  
5           2017, the Secretary shall make available to  
6           each MIPS eligible professional informa-  
7           tion, with respect to individuals who are  
8           patients of such MIPS eligible professional,  
9           about items and services for which pay-  
10          ment is made under this title that are fur-  
11          nished to such individuals by other sup-  
12          pliers and providers of services, which may  
13          include information described in clause (ii).  
14          Such information may be made available  
15          under the previous sentence to such MIPS  
16          eligible professionals by mechanisms deter-  
17          mined appropriate by the Secretary, which  
18          may include use of a web-based portal.  
19          Such information may be made available in  
20          accordance with the same or similar terms  
21          as data are made available to accountable  
22          care organizations participating in the  
23          shared savings program under section  
24          1899, including a beneficiary opt-out.

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

4           “(I) With respect to selected  
5 items and services (as determined ap-  
6 propriate by the Secretary) for which  
7 payment is made under this title and  
8 that are furnished to individuals, who  
9 are patients of a MIPS eligible profes-  
10 sional, by another supplier or provider  
11 of services during the most recent pe-  
12 riod for which data are available (such  
13 as the most recent three-month pe-  
14 riod), such as the name of such pro-  
15 viders furnishing such items and serv-  
16 ices to such patients during such pe-  
17 riod, the types of such items and serv-  
18 ices so furnished, and the dates such  
19 items and services were so furnished.

20           “(II) Historical data, such as  
21 averages and other measures of the  
22 distribution if appropriate, of the  
23 total, and components of, allowed  
24 charges (and other figures as deter-  
25 mined appropriate by the Secretary).

1 “(13) REVIEW.—

2 “(A) TARGETED REVIEW.—The Secretary  
3 shall establish a process under which a MIPS  
4 eligible professional may seek an informal re-  
5 view of the calculation of the MIPS adjustment  
6 factor applicable to such eligible professional  
7 under this subsection for a year. The results of  
8 a review conducted pursuant to the previous  
9 sentence shall not be taken into account for  
10 purposes of paragraph (6) with respect to a  
11 year (other than with respect to the calculation  
12 of such eligible professional’s MIPS adjustment  
13 factor for such year or additional MIPS adjust-  
14 ment factor for such year) after the factors de-  
15 termined in subparagraph (A) and subpara-  
16 graph (C) of such paragraph have been deter-  
17 mined for such year.

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

22 “(i) The methodology used to deter-  
23 mine the amount of the MIPS adjustment  
24 factor under paragraph (6)(A) and the  
25 amount of the additional MIPS adjustment

1 factor under paragraph (6)(C)(i) and the  
2 determination of such amounts.

3 “(ii) The establishment of the per-  
4 formance standards under paragraph (3)  
5 and the performance period under para-  
6 graph (4).

7 “(iii) The identification of measures  
8 and activities specified under paragraph  
9 (2)(B) and information made public or  
10 posted on the Physician Compare Internet  
11 website of the Centers for Medicare &  
12 Medicaid Services under paragraph (9).

13 “(iv) The methodology developed  
14 under paragraph (5) that is used to cal-  
15 culate performance scores and the calcula-  
16 tion of such scores, including the weighting  
17 of measures and activities under such  
18 methodology.”.

19 (2) GAO REPORTS.—

20 (A) EVALUATION OF ELIGIBLE PROFES-  
21 SIONAL MIPS.—Not later than October 1, 2019,  
22 and October 1, 2022, the Comptroller General  
23 of the United States shall submit to Congress  
24 a report evaluating the eligible professional  
25 Merit-based Incentive Payment System under

1 subsection (q) of section 1848 of the Social Se-  
2 curity Act (42 U.S.C. 1395w-4), as added by  
3 paragraph (1). Such report shall—

4 (i) examine the distribution of the  
5 composite performance scores and MIPS  
6 adjustment factors (and additional MIPS  
7 adjustment factors) for MIPS eligible pro-  
8 fessionals (as defined in subsection  
9 (q)(1)(c) of such section) under such pro-  
10 gram, and patterns relating to such scores  
11 and adjustment factors, including based on  
12 type of provider, practice size, geographic  
13 location, and patient mix;

14 (ii) provide recommendations for im-  
15 proving such program;

16 (iii) evaluate the impact of technical  
17 assistance funding under section  
18 1848(q)(11) of the Social Security Act, as  
19 added by paragraph (1), on the ability of  
20 professionals to improve within such pro-  
21 gram or successfully transition to an alter-  
22 native payment model (as defined in sec-  
23 tion 1833(z)(3) of the Social Security Act,  
24 as added by subsection (e)), with priority  
25 for such evaluation given to practices lo-



1 cated in rural areas, health professional  
2 shortage areas (as designated in section  
3 332(a)(1)(a) of the Public Health Service  
4 Act), and medically underserved areas; and

5 (iv) provide recommendations for opti-  
6 mizing the use of such technical assistance  
7 funds.

8 (B) STUDY TO EXAMINE ALIGNMENT OF  
9 QUALITY MEASURES USED IN PUBLIC AND PRI-  
10 VATE PROGRAMS.—

11 (i) IN GENERAL.—Not later than 18  
12 months after the date of the enactment of  
13 this Act, the Comptroller General of the  
14 United States shall submit to Congress a  
15 report that—

16 (I) compares the similarities and  
17 differences in the use of quality meas-  
18 ures under the original Medicare fee-  
19 for-service program under parts A and  
20 B of title XVIII of the Social Security  
21 Act, the Medicare Advantage program  
22 under part C of such title, selected  
23 State Medicaid programs under title  
24 XIX of such Act, and private payer  
25 arrangements; and

1 (II) makes recommendations on  
2 how to reduce the administrative bur-  
3 den involved in applying such quality  
4 measures.

5 (ii) REQUIREMENTS.—The report  
6 under clause (i) shall—

7 (I) consider those measures ap-  
8 plicable to individuals entitled to, or  
9 enrolled for, benefits under such part  
10 A, or enrolled under such part B and  
11 individuals under the age of 65; and

12 (II) focus on those measures that  
13 comprise the most significant compo-  
14 nent of the quality performance cat-  
15 egory of the eligible professional  
16 MIPS incentive program under sub-  
17 section (q) of section 1848 of the So-  
18 cial Security Act (42 U.S.C. 1395w-  
19 4), as added by paragraph (1).

20 (C) STUDY ON ROLE OF INDEPENDENT  
21 RISK MANAGERS.—Not later than January 1,  
22 2016, the Comptroller General of the United  
23 States shall submit to Congress a report exam-  
24 ining whether entities that pool financial risk  
25 for physician practices, such as independent

1 risk managers, can play a role in supporting  
2 physician practices, particularly small physician  
3 practices, in assuming financial risk for the  
4 treatment of patients. Such report shall exam-  
5 ine barriers that small physician practices cur-  
6 rently face in assuming financial risk for treat-  
7 ing patients, the types of risk management enti-  
8 ties that could assist physician practices in par-  
9 ticipating in two-sided risk payment models,  
10 and how such entities could assist with risk  
11 management and with quality improvement ac-  
12 tivities. Such report shall also include an anal-  
13 ysis of any existing legal barriers to such ar-  
14 rangements.

15 (D) STUDY TO EXAMINE RURAL AND  
16 HEALTH PROFESSIONAL SHORTAGE AREA AL-  
17 TERNATIVE PAYMENT MODELS.—Not later than  
18 October 1, 2020, and October 1, 2022, the  
19 Comptroller General of the United States shall  
20 submit to Congress a report that examines the  
21 transition of professionals in rural areas, health  
22 professional shortage areas (as designated in  
23 section 332(a)(1)(A) of the Public Health Serv-  
24 ice Act), or medically underserved areas to an  
25 alternative payment model (as defined in sec-

tion 1833(z)(3) of the Social Security Act, as added by subsection (e)). Such report shall make recommendations for removing administrative barriers to practices, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas to participation in such models.

(3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of \$80,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2014 through 2018. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

1                   (A)               IN               GENERAL.—Section  
 2               1848(m)(3)(C)(ii)) of the Social Security Act  
 3               (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended  
 4               by inserting “and, for 2015 and subsequent  
 5               years, may provide” after “shall provide”.

6                   (B) CLARIFICATION OF QUALIFIED CLIN-  
 7               ICAL DATA REGISTRY REPORTING TO GROUP  
 8               PRACTICES.—Section 1848(m)(3)(D) of the So-  
 9               cial Security Act (42 U.S.C. 1395w–  
 10              4(m)(3)(D)) is amended by inserting “and, for  
 11              2015 and subsequent years, subparagraph (A)  
 12              or (C)” after “subparagraph (A)”.

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

18                   (A) by striking “and subsequent years”  
 19                   and inserting “through reporting periods occur-  
 20                   ring in 2014”; and

21                   (B) by inserting “and, for reporting peri-  
 22                   ods occurring in 2015 and subsequent years,  
 23                   the Secretary may establish” following “shall  
 24                   establish”.

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

6           “(11) REPORTS ENDING WITH 2016.—Reports  
 7       under the Program shall not be provided after De-  
 8       cember 31, 2016. See subsection (q)(12) for reports  
 9       under the eligible professionals Merit-based Incentive  
 10      Payment System.”.

11          (4) COORDINATION WITH SATISFYING MEANING-  
 12      FUL EHR USE CLINICAL QUALITY MEASURE REPORT-  
 13      ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of  
 14      the Social Security Act (42 U.S.C. 1395w–  
 15      4(o)(2)(A)(iii)) is amended by inserting “and sub-  
 16      section (q)(5)(B)(ii)(II)” after “Subject to subpara-  
 17      graph (B)(ii)”.

18      (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

23      “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

24          “(1) TECHNICAL ADVISORY COMMITTEE.—

1           “(A) ESTABLISHMENT.—There is estab-  
2           lished an ad hoc committee to be known as the  
3           ‘Payment Model Technical Advisory Committee’  
4           (referred to in this subsection as the ‘Com-  
5           mittee’).

6           “(B) MEMBERSHIP.—

7           “(i) NUMBER AND APPOINTMENT.—  
8           The Committee shall be composed of 11  
9           members appointed by the Comptroller  
10          General of the United States.

11          “(ii) QUALIFICATIONS.—The member-  
12          ship of the Committee shall include indi-  
13          viduals with national recognition for their  
14          expertise in payment models and related  
15          delivery of care. No more than 5 members  
16          of the Committee shall be providers of  
17          services or suppliers, or representatives of  
18          providers of services or suppliers.

19          “(iii) PROHIBITION ON FEDERAL EM-  
20          PLOYMENT.—A member of the Committee  
21          shall not be an employee of the Federal  
22          Government.

23          “(iv) ETHICS DISCLOSURE.—The  
24          Comptroller General shall establish a sys-  
25          tem for public disclosure by members of

1 the Committee of financial and other po-  
2 tential conflicts of interest relating to such  
3 members. Members of the Committee shall  
4 be treated as employees of Congress for  
5 purposes of applying title I of the Ethics  
6 in Government Act of 1978 (Public Law  
7 95–521).

8 “(v) DATE OF INITIAL APPOINT-  
9 MENTS.—The initial appointments of mem-  
10 bers of the Committee shall be made by  
11 not later than 180 days after the date of  
12 enactment of this subsection.

13 “(C) TERM; VACANCIES.—

14 “(i) TERM.—The terms of members of  
15 the Committee shall be for 3 years except  
16 that the Comptroller General shall des-  
17 ignate staggered terms for the members  
18 first appointed.

19 “(ii) VACANCIES.—Any member ap-  
20 pointed to fill a vacancy occurring before  
21 the expiration of the term for which the  
22 member’s predecessor was appointed shall  
23 be appointed only for the remainder of that  
24 term. A member may serve after the expi-  
25 ration of that member’s term until a suc-



cessor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

“(D) DUTIES.—The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

“(E) COMPENSATION OF MEMBERS.—

“(i) IN GENERAL.—Except as provided in clause (ii), a member of the Committee shall serve without compensation.

“(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

“(F) OPERATIONAL AND TECHNICAL SUPPORT.—

“(i) IN GENERAL.—The Assistant Secretary for Planning and Evaluation

1 shall provide technical and operational sup-  
2 port for the Committee, which may be by  
3 use of a contractor. The Office of the Ac-  
4 tuary of the Centers for Medicare & Med-  
5 icaid Services shall provide to the Com-  
6 mittee actuarial assistance as needed.

7 “(ii) FUNDING.—The Secretary shall  
8 provide for the transfer, from the Federal  
9 Supplementary Medical Insurance Trust  
10 Fund under section 1841, such amounts as  
11 are necessary to carry out clause (i) (not  
12 to exceed \$5,000,000) for fiscal year 2014  
13 and each subsequent fiscal year. Any  
14 amounts transferred under the preceding  
15 sentence for a fiscal year shall remain  
16 available until expended.

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

20 “(2) CRITERIA AND PROCESS FOR SUBMISSION  
21 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT  
22 MODELS.—

23 “(A) CRITERIA FOR ASSESSING PHYSICIAN-  
24 FOCUSED PAYMENT MODELS.—

1 “(i) RULEMAKING.—Not later than  
2 November 1, 2015, the Secretary shall,  
3 through notice and comment rulemaking,  
4 following a request for information, estab-  
5 lish criteria for physician-focused payment  
6 models, including models for specialist phy-  
7 sicians, that could be used by the Com-  
8 mittee for making comments and rec-  
9 ommendations pursuant to paragraph  
10 (1)(D).

11 “(ii) MEDPAC SUBMISSION OF COM-  
12 MENTS.—During the comment period for  
13 the proposed rule described in clause (i),  
14 the Medicare Payment Advisory Commis-  
15 sion may submit comments to the Sec-  
16 retary on the proposed criteria under such  
17 clause.

18 “(iii) UPDATING.—The Secretary may  
19 update the criteria established under this  
20 subparagraph through rulemaking.

21 “(B) STAKEHOLDER SUBMISSION OF PHY-  
22 SICIAN FOCUSED PAYMENT MODELS.—On an  
23 ongoing basis, individuals and stakeholder enti-  
24 ties may submit to the Committee proposals for  
25 physician-focused payment models that such in-

1           dividuals and entities believe meet the criteria  
2           described in subparagraph (A).

3           “(C) TAC REVIEW OF MODELS SUB-  
4           MITTED.—The Committee shall, on a periodic  
5           basis, review models submitted under subpara-  
6           graph (B), prepare comments and recommenda-  
7           tions regarding whether such models meet the  
8           criteria described in subparagraph (A), and  
9           submit such comments and recommendations to  
10          the Secretary.

11          “(D) SECRETARY REVIEW AND RE-  
12          SPONSE.—The Secretary shall review the com-  
13          ments and recommendations submitted by the  
14          Committee under subparagraph (C) and post a  
15          detailed response to such comments and rec-  
16          ommendations on the Internet Website of the  
17          Centers for Medicare & Medicaid Services.

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

22          (2) INCENTIVE PAYMENTS FOR PARTICIPATION  
23          IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—  
24          Section 1833 of the Social Security Act (42 U.S.C.

1       1395l) is amended by adding at the end the fol-  
2       lowing new subsection:

3       “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN  
4 ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

5               “(1) PAYMENT INCENTIVE.—

6                       “(A) IN GENERAL.—In the case of covered  
7 professional services furnished by an eligible  
8 professional during a year that is in the period  
9 beginning with 2018 and ending with 2023 and  
10 for which the professional is a qualifying APM  
11 participant, in addition to the amount of pay-  
12 ment that would otherwise be made for such  
13 covered professional services under this part for  
14 such year, there also shall be paid to such pro-  
15 fessional an amount equal to 5 percent of the  
16 payment amount for the covered professional  
17 services under this part for the preceding year.  
18 For purposes of the previous sentence, the pay-  
19 ment amount for the preceding year may be an  
20 estimation for the full preceding year based on  
21 a period of such preceding year that is less than  
22 the full year. The Secretary shall establish poli-  
23 cies to implement this subparagraph in cases  
24 where payment for covered professional services  
25 furnished by a qualifying APM participant in

1 an alternative payment model is made to an en-  
2 tity participating in the alternative payment  
3 model rather than directly to the qualifying  
4 APM participant.

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

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

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

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

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

10                 “(A) 2018 AND 2019.—With respect to  
11                 2018 and 2019, an eligible professional for  
12                 whom the Secretary determines that at least 25  
13                 percent of payments under this part for covered  
14                 professional services furnished by such profes-  
15                 sional during the most recent period for which  
16                 data are available (which may be less than a  
17                 year) were attributable to such services fur-  
18                 nished under this part through an entity that  
19                 participates in an eligible alternative payment  
20                 model with respect to such services.

21                 “(B) 2020 AND 2021.—With respect to  
22                 2020 and 2021, an eligible professional de-  
23                 scribed in either of the following clauses:

24                         “(i) MEDICARE REVENUE THRESHOLD  
25                         OPTION.—An eligible professional for

1           whom the Secretary determines that at  
2           least 50 percent of payments under this  
3           part for covered professional services fur-  
4           nished by such professional during the  
5           most recent period for which data are  
6           available (which may be less than a year)  
7           were attributable to such services furnished  
8           under this part through an entity that par-  
9           ticipates in an eligible alternative payment  
10          model with respect to such services.

11                 “(ii) COMBINATION ALL-PAYER AND  
12           MEDICARE REVENUE THRESHOLD OP-  
13           TION.—An eligible professional—

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

21                                 “(aa) payments described in  
22                                 clause (i); and

23                                 “(bb) all other payments, re-  
24                                 gardless of payer (other than  
25                                 payments made by the Secretary



1 of Defense or the Secretary of  
2 Veterans Affairs under chapter  
3 55 of title 10, United States  
4 Code, or title 38, United States  
5 Code, or any other provision of  
6 law, and other than payments  
7 made under title XIX in a State  
8 in which no medical home or al-  
9 ternative payment model is avail-  
10 able under the State program  
11 under that title),  
12 meet the requirement described in  
13 clause (iii)(I) with respect to pay-  
14 ments described in item (aa) and meet  
15 the requirement described in clause  
16 (iii)(II) with respect to payments de-  
17 scribed in item (bb);  
18 “(II) for whom the Secretary de-  
19 termines at least 25 percent of pay-  
20 ments under this part for covered pro-  
21 fessional services furnished by such  
22 professional during the most recent  
23 period for which data are available  
24 (which may be less than a year) were  
25 attributable to such services furnished

1 under this part through an entity that  
2 participates in an eligible alternative  
3 payment model with respect to such  
4 services; and

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

10 “(iii) REQUIREMENT.—For purposes  
11 of clause (ii)(I)—

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

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

24 “(aa) quality measures com-  
25 parable to measures under the

1 performance category described  
2 in section 1848(q)(2)(B)(i) apply;

3 “(bb) certified EHR tech-  
4 nology is used; and

5 “(cc) the eligible profes-  
6 sional (AA) bears more than  
7 nominal financial risk if actual  
8 aggregate expenditures exceeds  
9 expected aggregate expenditures;  
10 or (BB) is a medical home (with  
11 respect to beneficiaries under  
12 title XIX) that meets criteria  
13 comparable to medical homes ex-  
14 panded under section 1115A(c).

15 “(C) BEGINNING IN 2022.—With respect to  
16 2022 and each subsequent year, an eligible pro-  
17 fessional described in either of the following  
18 clauses:

19 “(i) MEDICARE REVENUE THRESHOLD  
20 OPTION.—An eligible professional for  
21 whom the Secretary determines that at  
22 least 75 percent of payments under this  
23 part for covered professional services fur-  
24 nished by such professional during the  
25 most recent period for which data are

1 available (which may be less than a year)  
2 were attributable to such services furnished  
3 under this part through an entity that par-  
4 ticipates in an eligible alternative payment  
5 model with respect to such services.

6 “(ii) COMBINATION ALL-PAYER AND  
7 MEDICARE REVENUE THRESHOLD OP-  
8 TION.—An eligible professional—

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

16 “(aa) payments described in  
17 clause (i); and

18 “(bb) all other payments, re-  
19 gardless of payer (other than  
20 payments made by the Secretary  
21 of Defense or the Secretary of  
22 Veterans Affairs under chapter  
23 55 of title 10, United States  
24 Code, or title 38, United States  
25 Code, or any other provision of

1 law, and other than payments  
2 made under title XIX in a State  
3 in which no medical home or al-  
4 ternative payment model is avail-  
5 able under the State program  
6 under that title),  
7 meet the requirement described in  
8 clause (iii)(I) with respect to pay-  
9 ments described in item (aa) and meet  
10 the requirement described in clause  
11 (iii)(II) with respect to payments de-  
12 scribed in item (bb);  
13 “(II) for whom the Secretary de-  
14 termines at least 25 percent of pay-  
15 ments under this part for covered pro-  
16 fessional services furnished by such  
17 professional during the most recent  
18 period for which data are available  
19 (which may be less than a year) were  
20 attributable to such services furnished  
21 under this part through an entity that  
22 participates in an eligible alternative  
23 payment model with respect to such  
24 services; and

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

6 “(iii) REQUIREMENT.—For purposes  
7 of clause (ii)(I)—

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

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

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

24 “(bb) certified EHR tech-  
25 nology is used; and

1                   “(cc) the eligible profes-  
2                   sional (AA) bears more than  
3                   nominal financial risk if actual  
4                   aggregate expenditures exceeds  
5                   expected aggregate expenditures;  
6                   or (BB) is a medical home (with  
7                   respect to beneficiaries under  
8                   title XIX) that meets criteria  
9                   comparable to medical homes ex-  
10                  panded under section 1115A(c).

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

13                   “(A) COVERED PROFESSIONAL SERV-  
14                   ICES.—The term ‘covered professional services’  
15                   has the meaning given that term in section  
16                   1848(k)(3)(A).

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

20                   “(C) ALTERNATIVE PAYMENT MODEL  
21                   (APM).—The term ‘alternative payment model’  
22                   means any of the following:

23                   “(i) A model under section 1115A  
24                   (other than a health care innovation  
25                   award).

1 “(ii) The shared savings program  
2 under section 1899.

3 “(iii) A demonstration under section  
4 1866C.

5 “(iv) A demonstration required by  
6 Federal law.

7 “(D) ELIGIBLE ALTERNATIVE PAYMENT  
8 MODEL (APM).—

9 “(i) IN GENERAL.—The term ‘eligible  
10 alternative payment model’ means, with re-  
11 spect to a year, an alternative payment  
12 model—

13 “(I) that requires use of certified  
14 EHR technology (as defined in sub-  
15 section (o)(4));

16 “(II) that provides for payment  
17 for covered professional services based  
18 on quality measures comparable to  
19 measures under the performance cat-  
20 egory described in section  
21 1848(q)(2)(B)(i); and

22 “(III) that satisfies the require-  
23 ment described in clause (ii).

24 “(ii) ADDITIONAL REQUIREMENT.—  
25 For purposes of clause (i)(III), the require-



1           ment described in this clause, with respect  
2           to a year and an alternative payment  
3           model, is that the alternative payment  
4           model—

5                   “(I) is one in which one or more  
6                   entities bear financial risk for mone-  
7                   tary losses under such model that are  
8                   in excess of a nominal amount; or

9                   “(II) is a medical home expanded  
10                  under section 1115A(c).

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

14                   “(A) The determination that an eligible  
15                   professional is a qualifying APM participant  
16                   under paragraph (2) and the determination  
17                   that an alternative payment model is an eligible  
18                   alternative payment model under paragraph  
19                   (3)(D).

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

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

4                   (A) in subsection (x)(3), by adding at the  
5                   end the following new sentence: “The amount  
6                   of the additional payment for a service under  
7                   this subsection and subsection (z) shall be de-  
8                   termined without regard to any additional pay-  
9                   ment for the service under subsection (z) and  
10                  this subsection, respectively.”; and

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

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

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

24                           “(xxi) Focusing primarily on physi-  
25                           cians’ services (as defined in section

1 1848(j)(3)) furnished by physicians who  
2 are not primary care practitioners.

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

5 “(xxiii) Focusing on risk-based models  
6 for small physician practices which may in-  
7 volve two-sided risk and prospective patient  
8 assignment, and which examine risk-ad-  
9 justed decreases in mortality rates, hos-  
10 pital readmissions rates, and other relevant  
11 and appropriate clinical measures.

12 “(xxiv) Focusing primarily on title  
13 XIX, working in conjunction with the Cen-  
14 ter for Medicaid and CHIP Services.”; and

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

20 (5) CONSTRUCTION REGARDING TELEHEALTH  
21 SERVICES.—Nothing in the provisions of, or amend-  
22 ments made by, this Act shall be construed as pre-  
23 cluding an alternative payment model or a qualifying  
24 APM participant (as those terms are defined in sec-  
25 tion 1833(z) of the Social Security Act, as added by

1 paragraph (1)) from furnishing a telehealth service  
2 for which payment is not made under section  
3 1834(m) of the Social Security Act (42 U.S.C.  
4 1395m(m)).

5 (6) INTEGRATING MEDICARE ADVANTAGE AL-  
6 TERNATIVE PAYMENT MODELS.—Not later than July  
7 1, 2015, the Secretary of Health and Human Serv-  
8 ices shall submit to Congress a study that examines  
9 the feasibility of integrating alternative payment  
10 models in the Medicare Advantage payment system.  
11 The study shall include the feasibility of including a  
12 value-based modifier and whether such modifier  
13 should be budget neutral.

14 (7) STUDY AND REPORT ON FRAUD RELATED  
15 TO ALTERNATIVE PAYMENT MODELS UNDER THE  
16 MEDICARE PROGRAM.—

17 (A) STUDY.—The Secretary of Health and  
18 Human Services, in consultation with the In-  
19 spector General of the Department of Health  
20 and Human Services, shall conduct a study  
21 that—

22 (i) examines the applicability of the  
23 Federal fraud prevention laws to items and  
24 services furnished under title XVIII of the  
25 Social Security Act for which payment is

1           made under an alternative payment model  
2           (as defined in section 1833(z)(3)(C) of  
3           such Act (42 U.S.C. 1395l(z)(3)(C)));

4           (ii) identifies aspects of such alter-  
5           native payment models that are vulnerable  
6           to fraudulent activity; and

7           (iii) examines the implications of waiv-  
8           ers to such laws granted in support of such  
9           alternative payment models, including  
10          under any potential expansion of such  
11          models.

12          (B) REPORT.—Not later than 2 years after  
13          the date of the enactment of this Act, the Sec-  
14          retary shall submit to Congress a report con-  
15          taining the results of the study conducted under  
16          subparagraph (A). Such report shall include  
17          recommendations for actions to be taken to re-  
18          duce the vulnerability of such alternative pay-  
19          ment models to fraudulent activity. Such report  
20          also shall include, as appropriate, recommenda-  
21          tions of the Inspector General for changes in  
22          Federal fraud prevention laws to reduce such  
23          vulnerability.

24          (f) IMPROVING PAYMENT ACCURACY.—

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

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

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

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

6 (B) STUDY USING OTHER DATA.—

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

22 (ii) REPORT.—Not later than 5 years  
23 after the date of the enactment of this Act,  
24 the Secretary shall submit to Congress a

1 report on the study conducted under clause  
2 (i).

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

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

24 (i) obtain access to the necessary data  
25 (if such data is not already being collected)



1 on such factors, including recommenda-  
2 tions on how to address barriers to the  
3 Centers in accessing such data; and

4 (ii) account for such factors in deter-  
5 mining payment adjustments based on  
6 quality and resource use outcome measures  
7 under the eligible professional Merit-based  
8 Incentive Payment System under section  
9 1848(q) of the Social Security Act (42  
10 U.S.C. 1395w–4(q)) and, as the Secretary  
11 determines appropriate, other similar pro-  
12 visions of title XVIII of such Act.

13 (E) FUNDING.—There are hereby appro-  
14 priated from the Federal Supplementary Med-  
15 ical Insurance Trust Fund under section 1841  
16 of the Social Security Act to the Secretary to  
17 carry out this paragraph \$6,000,000, to remain  
18 available until expended.

19 (2) CMS ACTIVITIES.—

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

1 an individual's health status and other risk fac-  
2 tors affect quality and resource use outcome  
3 measures and, as feasible, shall incorporate in-  
4 formation from quality and resource use out-  
5 come measurement (including care episode and  
6 patient condition groups) into provisions of title  
7 XVIII of the Social Security Act that are simi-  
8 lar to the eligible professional Merit-based In-  
9 centive Payment System under section 1848(q)  
10 of such Act.

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

13 (i) IN GENERAL.—Taking into ac-  
14 count the studies conducted and rec-  
15 ommendations made in reports under para-  
16 graph (1) and other information as appro-  
17 priate, the Secretary shall, as the Sec-  
18 retary determines appropriate, account for  
19 identified factors with an effect on quality  
20 and resource use outcome measures when  
21 determining payment adjustment mecha-  
22 nisms under provisions of title XVIII of  
23 the Social Security Act that are similar to  
24 the eligible professional Merit-based Incen-

1           tive Payment System under section  
2           1848(q) of such Act.

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

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

13          (C) FUNDING.—There are hereby appro-  
14          priated from the Federal Supplementary Med-  
15          ical Insurance Trust Fund under section 1841  
16          of the Social Security Act to the Secretary to  
17          carry out this paragraph and the application of  
18          this paragraph to the Merit-based Incentive  
19          Payment System under section 1848(q) of such  
20          Act \$10,000,000, to remain available until ex-  
21          pended.

22          (3) STRATEGIC PLAN FOR ACCESSING RACE  
23          AND ETHNICITY DATA.—Not later than 18 months  
24          after the date of the enactment of this Act, the Sec-  
25          retary shall develop and report to Congress on a

1 strategic plan for collecting or otherwise accessing  
2 data on race and ethnicity for purposes of carrying  
3 out the eligible professional Merit-based Incentive  
4 Payment System under section 1848(q) of the Social  
5 Security Act and, as the Secretary determines ap-  
6 propriate, other similar provisions of title XVIII of  
7 such Act.

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

14 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-  
15 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO  
16 IMPROVE RESOURCE USE MEASUREMENT.—

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

1           “(2) DEVELOPMENT OF CARE EPISODE AND PA-  
2           TIENT CONDITION GROUPS AND CLASSIFICATION  
3           CODES.—

4           “(A) IN GENERAL.—In order to classify  
5           similar patients into care episode groups and  
6           patient condition groups, the Secretary shall  
7           undertake the steps described in the succeeding  
8           provisions of this paragraph.

9           “(B) PUBLIC AVAILABILITY OF EXISTING  
10          EFFORTS TO DESIGN AN EPISODE GROUPE.—  
11          Not later than 120 days after the date of the  
12          enactment of this subsection, the Secretary  
13          shall post on the Internet website of the Cen-  
14          ters for Medicare & Medicaid Services a list of  
15          the episode groups developed pursuant to sub-  
16          section (n)(9)(A) and related descriptive infor-  
17          mation.

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

specific clinical criteria and patient characteristics to classify patients into—

“(i) care episode groups; and

“(ii) patient condition groups.

“(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

“(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received 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

1 care, such as the clinical conditions or  
2 diagnoses, whether or not inpatient  
3 hospitalization is anticipated or oc-  
4 curs, and the principal procedures or  
5 services planned or furnished; and

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

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

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

20 “(II) other factors determined  
21 appropriate by the Secretary, such as  
22 eligibility status under this title (in-  
23 cluding eligibility under section  
24 226(a), 226(b), or 226A, and dual eli-  
25 gibility under this title and title XIX).

1           “(E) DRAFT CARE EPISODE AND PATIENT  
2           CONDITION GROUPS AND CLASSIFICATION  
3           CODES.—Not later than 180 days after the end  
4           of the comment period described in subpara-  
5           graph (C), the Secretary shall post on the  
6           Internet website of the Centers for Medicare &  
7           Medicaid Services a draft list of the care epi-  
8           sode and patient condition codes established  
9           under subparagraph (D) (and the criteria and  
10          characteristics assigned to such code).

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



“(G) OPERATIONAL LIST OF CARE EPI-  
SODE AND PATIENT CONDITION GROUPS AND  
CODES.—Not later than 180 days after the end  
of the comment period described in subpara-  
graph (F), taking into account the comments  
received under such subparagraph, the Sec-  
retary shall post on the Internet website of the  
Centers for Medicare & Medicaid Services an  
operational list of care episode and patient con-  
dition codes (and the criteria and characteris-  
tics assigned to such code).

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

1           “(3) ATTRIBUTION OF PATIENTS TO PHYSI-  
2           CIANS OR PRACTITIONERS.—

3           “(A) IN GENERAL.—In order to facilitate  
4           the attribution of patients and episodes (in  
5           whole or in part) to one or more physicians or  
6           applicable practitioners furnishing items and  
7           services, the Secretary shall undertake the steps  
8           described in the succeeding provisions of this  
9           paragraph.

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

23                 “(i) considers himself to have the  
24                 primary responsibility for the general and

1 ongoing care for the patient over extended  
2 periods of time;

3 “(ii) considers themselves to be the lead  
4 physician or practitioner and who furnishes  
5 items and services and coordinates care  
6 furnished by other physicians or practi-  
7 tioners for the patient during an acute epi-  
8 sode;

9 “(iii) furnishes items and services to  
10 the patient on a continuing basis during an  
11 acute episode of care, but in a supportive  
12 rather than a lead role;

13 “(iv) furnishes items and services to  
14 the patient on an occasional basis, usually  
15 at the request of another physician or  
16 practitioner; or

17 “(v) furnishes items and services only  
18 as ordered by another physician or practi-  
19 tioner.

20 “(C) DRAFT LIST OF PATIENT RELATION-  
21 SHIP CATEGORIES AND CODES.—Not later than  
22 270 days after the date of the enactment of this  
23 subsection, the Secretary shall post on the  
24 Internet website of the Centers for Medicare &  
25 Medicaid Services a draft list of the patient re-

1 relationship categories and codes developed under  
2 subparagraph (B).

3 “(D) STAKEHOLDER 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 (C), 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 patient relationship categories and  
12 codes posted under subparagraph (C). In seek-  
13 ing such comments, the Secretary shall use one  
14 or more mechanisms (other than notice and  
15 comment rulemaking) that may include open  
16 door forums, town hall meetings, or other ap-  
17 propriate mechanisms.

18 “(E) OPERATIONAL LIST OF PATIENT RE-  
19 LATIONSHIP CATEGORIES AND CODES.—Not  
20 later than 180 days after the end of the com-  
21 ment period described in subparagraph (D),  
22 taking into account the comments received  
23 under such subparagraph, the Secretary shall  
24 post on the Internet website of the Centers for

1 Medicare & Medicaid Services an operational  
2 list of patient relationship categories and codes.

3 “(F) SUBSEQUENT REVISIONS.—Not later  
4 than November 1 of each year (beginning with  
5 2017), the Secretary shall, through rulemaking,  
6 make revisions to the operational list of patient  
7 relationship categories and codes as the Sec-  
8 retary determines appropriate. Such revisions  
9 may be based on experience, new information  
10 developed pursuant to subsection (n)(9)(A), and  
11 input from the physician specialty societies, ap-  
12 plicable practitioner organizations, and other  
13 stakeholders, including representatives of indi-  
14 viduals entitled to benefits under part A or en-  
15 rolled under this part.

16 “(4) REPORTING OF INFORMATION FOR RE-  
17 SOURCE USE MEASUREMENT.—Claims submitted for  
18 items and services furnished by a physician or appli-  
19 cable practitioner on or after January 1, 2017, shall,  
20 as determined appropriate by the Secretary, in-  
21 clude—

22 “(A) applicable codes established under  
23 paragraphs (2) and (3); and

24 “(B) the national provider identifier of the  
25 ordering physician or applicable practitioner (if

different from the billing physician or applicable practitioner).

“(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

“(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall—

“(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

“(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

“(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

“(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with

1           respect to patients attributed to physicians and  
2           applicable practitioners, the Secretary shall, as  
3           feasible—

4                   “(i) use the claims data experience of  
5                   such patients by patient condition codes  
6                   during a common period, such as 12  
7                   months; and

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

10                   “(I) in the case of episodes with-  
11                   out a hospitalization, during periods  
12                   of time (such as the number of days)  
13                   determined appropriate by the Sec-  
14                   retary; and

15                   “(II) in the case of episodes with  
16                   a hospitalization, during periods of  
17                   time (such as the number of days) be-  
18                   fore, during, and after the hospitaliza-  
19                   tion.

20                   “(C) MEASUREMENT OF RESOURCE USE.—

21           In measuring such resource use, the Sec-  
22           retary—

23                   “(i) shall use per patient total allowed  
24                   charges for all services under part A and  
25                   this part (and, if the Secretary determines

1 appropriate, part D) for the analysis of pa-  
2 tient resource use, by care episode codes  
3 and by patient condition codes; and

4 “(ii) may, as determined appropriate,  
5 use other measures of allowed charges  
6 (such as subtotals for categories of items  
7 and services) and measures of utilization of  
8 items and services (such as frequency of  
9 specific items and services and the ratio of  
10 specific items and services among attrib-  
11 uted patients or episodes).

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



1           “(6) IMPLEMENTATION.—To the extent that  
2           the Secretary contracts with an entity to carry out  
3           any part of the provisions of this subsection, the  
4           Secretary may not contract with an entity or an en-  
5           tity with a subcontract if the entity or subcon-  
6           tracting entity currently makes recommendations to  
7           the Secretary on relative values for services under  
8           the fee schedule for physicians’ services under this  
9           section.

10           “(7) LIMITATION.—There shall be no adminis-  
11           trative or judicial review under section 1869, section  
12           1878, or otherwise of—

13                   “(A) care episode and patient condition  
14                   groups and codes established under paragraph  
15                   (2);

16                   “(B) patient relationship categories and  
17                   codes established under paragraph (3); and

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

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

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

1                   “(A) PHYSICIAN.—The term ‘physician’  
 2                   has the meaning given such term in section  
 3                   1861(r)(1).

4                   “(B) APPLICABLE PRACTITIONER.—The  
 5                   term ‘applicable practitioner’ means—

6                   “(i) a physician assistant, nurse prac-  
 7                   titioner, and clinical nurse specialist (as  
 8                   such terms are defined in section  
 9                   1861(aa)(5)), and a certified registered  
 10                  nurse anesthetist (as defined in section  
 11                  1861(bb)(2)); and

12                  “(ii) beginning January 1, 2018, such  
 13                  other eligible professionals (as defined in  
 14                  subsection (k)(3)(B)) as specified by the  
 15                  Secretary.

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

19 **SEC. 3. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**  
 20 **OPMENT.**

21                  Section 1848 of the Social Security Act (42 U.S.C.  
 22                  1395w-4), as amended by subsections (c) and (g) of sec-  
 23                  tion 2, is further amended by inserting at the end the fol-  
 24                  lowing new subsection:

1       “(s) PRIORITIES AND FUNDING FOR MEASURE DE-  
2   VELOPMENT.—

3               “(1) PLAN IDENTIFYING MEASURE DEVELOP-  
4   MENT PRIORITIES AND TIMELINES.—

5               “(A) DRAFT MEASURE DEVELOPMENT  
6   PLAN.—Not later than January 1, 2015, the  
7   Secretary shall develop, and post on the Inter-  
8   net website of the Centers for Medicare & Med-  
9   icaid Services, a draft plan for the development  
10   of quality measures for application under the  
11   applicable provisions (as defined in paragraph  
12   (5)). Under such plan the Secretary shall—

13               “(i) address how measures used by  
14   private payers and integrated delivery sys-  
15   tems could be incorporated under title  
16   XVIII;

17               “(ii) describe how coordination, to the  
18   extent possible, will occur across organiza-  
19   tions developing such measures; and

20               “(iii) take into account how clinical  
21   best practices and clinical practice guide-  
22   lines should be used in the development of  
23   quality measures.

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

4 “(i) Clinical care.

5 “(ii) Safety.

6 “(iii) Care coordination.

7 “(iv) Patient and caregiver experience.

8 “(v) Population health and preven-  
9 tion.

10 “(C) CONSIDERATION.—In developing the  
11 draft plan under this paragraph, the Secretary  
12 shall consider—

13 “(i) gap analyses conducted by the en-  
14 tity with a contract under section 1890(a)  
15 or other contractors or entities;

16 “(ii) whether measures are applicable  
17 across health care settings;

18 “(iii) clinical practice improvement ac-  
19 tivities submitted under subsection  
20 (q)(2)(C)(iv) for identifying possible areas  
21 for future measure development and identi-  
22 fying existing gaps with respect to such  
23 measures; and

24 “(iv) the quality domains applied  
25 under this subsection.

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

4                   “(i) Outcome measures, including pa-  
5                   tient reported outcome and functional sta-  
6                   tus measures.

7                   “(ii) Patient experience measures.

8                   “(iii) Care coordination measures.

9                   “(iv) Measures of appropriate use of  
10                  services, including measures of over use.

11           “(E) STAKEHOLDER INPUT.—The Sec-  
12           retary shall accept through March 1, 2015,  
13           comments on the draft plan posted under para-  
14           graph (1)(A) from the public, including health  
15           care providers, payers, consumers, and other  
16           stakeholders.

17           “(F) FINAL MEASURE DEVELOPMENT  
18           PLAN.—Not later than May 1, 2015, taking  
19           into account the comments received under this  
20           subparagraph, the Secretary shall finalize the  
21           plan and post on the Internet website of the  
22           Centers for Medicare & Medicaid Services an  
23           operational plan for the development of quality  
24           measures for use under the applicable provi-

1           sions. Such plan shall be updated as appro-  
2           prium.

3           “(2) CONTRACTS AND OTHER ARRANGEMENTS  
4           FOR QUALITY MEASURE DEVELOPMENT.—

5           “(A) IN GENERAL.—The Secretary shall  
6           enter into contracts or other arrangements with  
7           entities for the purpose of developing, improv-  
8           ing, updating, or expanding in accordance with  
9           the plan under paragraph (1) quality measures  
10          for application under the applicable provisions.  
11          Such entities shall include organizations with  
12          quality measure development expertise.

13          “(B) PRIORITIZATION.—

14          “(i) IN GENERAL.—In entering into  
15          contracts or other arrangements under  
16          subparagraph (A), the Secretary shall give  
17          priority to the development of the types of  
18          measures described in paragraph (1)(D).

19          “(ii) CONSIDERATION.—In selecting  
20          measures for development under this sub-  
21          section, the Secretary shall consider—

22                  “(I) whether such measures  
23                  would be electronically specified; and

1                   “(II) clinical practice guidelines  
2                   to the extent that such guidelines  
3                   exist.

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

5                   “(A) IN GENERAL.—Not later than May 1,  
6                   2016, and annually thereafter, the Secretary  
7                   shall post on the Internet website of the Cen-  
8                   ters for Medicare & Medicaid Services a report  
9                   on the progress made in developing quality  
10                  measures for application under the applicable  
11                  provisions.

12                  “(B) REQUIREMENTS.—Each report sub-  
13                  mitted pursuant to subparagraph (A) shall in-  
14                  clude the following:

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

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

19                               “(I) a description of the total  
20                               number of quality measures developed  
21                               and the types of such measures, such  
22                               as an outcome or patient experience  
23                               measure;

24                               “(II) the name of each measure  
25                               developed;

1 “(III) the name of the developer  
2 and steward of each measure;

3 “(IV) with respect to each type  
4 of measure, an estimate of the total  
5 amount expended under this title to  
6 develop all measures of such type; and

7 “(V) whether the measure would  
8 be electronically specified.

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

11 “(I) the information described in  
12 clause (ii), if available; and

13 “(II) a timeline for completion of  
14 the development of such measures.

15 “(iv) A description of any updates to  
16 the plan under paragraph (1) (including  
17 newly identified gaps and the status of pre-  
18 viously identified gaps) and the inventory  
19 of measures applicable under the applicable  
20 provisions.

21 “(v) Other information the Secretary  
22 determines to be appropriate.

23 “(4) STAKEHOLDER INPUT.—With respect to  
24 paragraph (1), the Secretary shall seek stakeholder  
25 input with respect to—



1           “(A) the identification of gaps where no  
2           quality measures exist, particularly with respect  
3           to the types of measures described in paragraph  
4           (1)(D);

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

7           “(C) other areas related to quality measure  
8           development determined appropriate by the Sec-  
9           retary.

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

13               “(A) Subsection (q)(2)(B)(i).

14               “(B) Section 1833(z)(2)(C).

15          “(6) FUNDING.—For purposes of carrying out  
16          this subsection, the Secretary shall provide for the  
17          transfer, from the Federal Supplementary Medical  
18          Insurance Trust Fund under section 1841, of  
19          \$15,000,000 to the Centers for Medicare & Medicaid  
20          Services Program Management Account for each of  
21          fiscal years 2014 through 2018. Amounts trans-  
22          ferred under this paragraph shall remain available  
23          through the end of fiscal year 2021.”.

1 **SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVID-**  
2 **UALS WITH CHRONIC CARE NEEDS.**

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

6 “(8) ENCOURAGING CARE MANAGEMENT FOR  
7 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

8 “(A) IN GENERAL.—In order to encourage  
9 the management of care by an applicable pro-  
10 vider (as defined in subparagraph (B)) for indi-  
11 viduals with chronic care needs the Secretary  
12 shall—

13 “(i) establish one or more HCPCS  
14 codes for chronic care management serv-  
15 ices for such individuals; and

16 “(ii) subject to subparagraph (D),  
17 make payment (as the Secretary deter-  
18 mines to be appropriate) under this section  
19 for such management services furnished on  
20 or after January 1, 2015, by an applicable  
21 provider.

22 “(B) APPLICABLE PROVIDER DEFINED.—  
23 For purposes of this paragraph, the term ‘ap-  
24 plicable provider’ means a physician (as defined  
25 in section 1861(r)(1)), physician assistant or  
26 nurse practitioner (as defined in section

1 1861(aa)(5)(A)), or clinical nurse specialist (as  
2 defined in section 1861(aa)(5)(B)) who fur-  
3 nishes services as part of a patient-centered  
4 medical home or a comparable specialty practice  
5 that—

6 “(i) is recognized as such a medical  
7 home or comparable specialty practice by  
8 an organization that is recognized by the  
9 Secretary for purposes of such recognition  
10 as such a medical home or practice; or

11 “(ii) meets such other comparable  
12 qualifications as the Secretary determines  
13 to be appropriate.

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

18 “(D) POLICIES RELATING TO PAYMENT.—  
19 In carrying out this paragraph, with respect to  
20 chronic care management services, the Sec-  
21 retary shall—

22 “(i) make payment to only one appli-  
23 cable provider for such services furnished  
24 to an individual during a period;

1 “(ii) not make payment under sub-  
 2 paragraph (A) if such payment would be  
 3 duplicative of payment that is otherwise  
 4 made under this title for such services  
 5 (such as in the case of hospice care or  
 6 home health services); and

7 “(iii) not require that an annual  
 8 wellness visit (as defined in section  
 9 1861(hhh)) or an initial preventive phys-  
 10 ical examination (as defined in section  
 11 1861(ww)) be furnished as a condition of  
 12 payment for such management services.”.

13 (b) EDUCATION AND OUTREACH.—

14 (1) CAMPAIGN.—

15 (A) IN GENERAL.—The Secretary of  
 16 Health and Human Services (in this subsection  
 17 referred to as the “Secretary”) shall conduct an  
 18 education and outreach campaign to inform  
 19 professionals who furnish items and services  
 20 under part B of title XVIII of the Social Secu-  
 21 rity Act and individuals enrolled under such  
 22 part of the benefits of chronic care management  
 23 services described in section 1848(b)(8) of the  
 24 Social Security Act, as added by subsection (a),

1 and encourage such individuals with chronic  
2 care needs to receive such services.

3 (B) REQUIREMENTS.—Such campaign  
4 shall—

5 (i) be directed by the Office of Rural  
6 Health Policy of the Department of Health  
7 and Human Services and the Office of Mi-  
8 nority Health of the Centers for Medicare  
9 & Medicaid Services; and

10 (ii) focus on encouraging participation  
11 by underserved rural populations and ra-  
12 cial and ethnic minority populations.

13 (2) REPORT.—

14 (A) IN GENERAL.—Not later than Decem-  
15 ber 31, 2017, the Secretary shall submit to  
16 Congress a report on the use of chronic care  
17 management services described in such section  
18 1848(b)(8) by individuals living in rural areas  
19 and by racial and ethnic minority populations.  
20 Such report shall—

21 (i) identify barriers to receiving chron-  
22 ic care management services; and

23 (ii) make recommendations for in-  
24 creasing the appropriate use of chronic  
25 care management services.

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

3 (a) **AUTHORITY TO COLLECT AND USE INFORMA-**  
4 **TION ON PHYSICIANS' SERVICES IN THE DETERMINATION**  
5 **OF RELATIVE VALUES.—**

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

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

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

23 “(ii) **USE OF INFORMATION.**—Not-  
24 withstanding any other provision of law,  
25 subject to clause (v), the Secretary may  
26 (as the Secretary determines appropriate)

1 use information collected or obtained pur-  
2 suant to clause (i) in the determination of  
3 relative values for services under this sec-  
4 tion.

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

9 “(I) Time involved in furnishing  
10 services.

11 “(II) Amounts and types of prac-  
12 tice expense inputs involved with fur-  
13 nishing services.

14 “(III) Prices (net of any dis-  
15 counts) for practice expense inputs,  
16 which may include paid invoice prices  
17 or other documentation or records.

18 “(IV) Overhead and accounting  
19 information for practices of physicians  
20 and other suppliers.

21 “(V) Any other element that  
22 would improve the valuation of serv-  
23 ices under this section.

24 “(iv) INFORMATION COLLECTION  
25 MECHANISMS.—Information may be col-

1 lected or obtained pursuant to this sub-  
2 paragraph from any or all of the following:

3 “(I) Surveys of physicians, other  
4 suppliers, providers of services, manu-  
5 facturers, and vendors.

6 “(II) Surgical logs, billing sys-  
7 tems, or other practice or facility  
8 records.

9 “(III) Electronic health records.

10 “(IV) Any other mechanism de-  
11 termined appropriate by the Sec-  
12 retary.

13 “(v) TRANSPARENCY OF USE OF IN-  
14 FORMATION.—

15 “(I) IN GENERAL.—Subject to  
16 subclauses (II) and (III), if the Sec-  
17 retary uses information collected or  
18 obtained under this subparagraph in  
19 the determination of relative values  
20 under this subsection, the Secretary  
21 shall disclose the information source  
22 and discuss the use of such informa-  
23 tion in such determination of relative  
24 values through notice and comment  
25 rulemaking.



1 “(II) THRESHOLDS FOR USE.—

2 The Secretary may establish thresh-  
3 olds in order to use such information,  
4 including the exclusion of information  
5 collected or obtained from eligible pro-  
6 fessionals who use very high resources  
7 (as determined by the Secretary) in  
8 furnishing a service.

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

18 “(vi) INCENTIVE TO PARTICIPATE.—

19 The Secretary may provide for such pay-  
20 ments under this part to an eligible profes-  
21 sional that submits such solicited informa-  
22 tion under this subparagraph as the Sec-  
23 retary determines appropriate in order to  
24 compensate such eligible professional for  
25 such submission. Such payments shall be

1 provided in a form and manner specified  
2 by the Secretary.

3 “(vii) ADMINISTRATION.—Chapter 35  
4 of title 44, United States Code, shall not  
5 apply to information collected or obtained  
6 under this subparagraph.

7 “(viii) DEFINITION OF ELIGIBLE PRO-  
8 FESSIOAL.—In this subparagraph, the  
9 term ‘eligible professional’ has the meaning  
10 given such term in subsection (k)(3)(B).

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

23 (2) LIMITATION ON REVIEW.—Section  
24 1848(i)(1) of the Social Security Act (42 U.S.C.  
25 1395w-4(i)(1)) is amended—

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

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

5 (C) by adding at the end the following new  
6 subparagraph:

7 “(F) the collection and use of information  
8 in the determination of relative values under  
9 subsection (c)(2)(M).”.

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

16 “(N) AUTHORITY FOR ALTERNATIVE AP-  
17 PROACHES TO ESTABLISHING PRACTICE EX-  
18 PENSE RELATIVE VALUES.—The Secretary may  
19 establish or adjust practice expense relative val-  
20 ues under this subsection using cost, charge, or  
21 other data from suppliers or providers of serv-  
22 ices, including information collected or obtained  
23 under subparagraph (M).”.

24 (c) REVISED AND EXPANDED IDENTIFICATION OF  
25 POTENTIALLY MISVALUED CODES.—Section

1 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.  
2 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

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

10 “(I) Codes that have experienced  
11 the fastest growth.

12 “(II) Codes that have experi-  
13 enced substantial changes in practice  
14 expenses.

15 “(III) Codes that describe new  
16 technologies or services within an ap-  
17 propriate time period (such as 3  
18 years) after the relative values are ini-  
19 tially established for such codes.

20 “(IV) Codes which are multiple  
21 codes that are frequently billed in con-  
22 junction with furnishing a single serv-  
23 ice.

24 “(V) Codes with low relative val-  
25 ues, particularly those that are often

1 billed multiple times for a single treat-  
2 ment.

3 “(VI) Codes that have not been  
4 subject to review since implementation  
5 of the fee schedule.

6 “(VII) Codes that account for  
7 the majority of spending under the  
8 physician fee schedule.

9 “(VIII) Codes for services that  
10 have experienced a substantial change  
11 in the hospital length of stay or proce-  
12 dure time.

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

16 “(X) Codes for which there is a  
17 significant difference in payment for  
18 the same service between different  
19 sites of service.

20 “(XI) Codes for which there may  
21 be anomalies in relative values within  
22 a family of codes.

23 “(XII) Codes for services where  
24 there may be efficiencies when a serv-

1 ice is furnished at the same time as  
2 other services.

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

5 “(XIV) Codes with high practice  
6 expense relative value units.

7 “(XV) Codes with high cost sup-  
8 plies.

9 “(XVI) Codes as determined ap-  
10 propriate by the Secretary.”.

11 (d) TARGET FOR RELATIVE VALUE ADJUSTMENTS  
12 FOR MISVALUED SERVICES.—

13 (1) IN GENERAL.—Section 1848(c)(2) of the  
14 Social Security Act (42 U.S.C. 1395w–4(c)(2)), as  
15 amended by subsections (a) and (b), is amended by  
16 adding at the end the following new subparagraph:

17 “(O) TARGET FOR RELATIVE VALUE AD-  
18 JUSTMENTS FOR MISVALUED SERVICES.—With  
19 respect to fee schedules established for each of  
20 2015 through 2018, the following shall apply:

21 “(i) DETERMINATION OF NET REDUC-  
22 TION IN EXPENDITURES.—For each year,  
23 the Secretary shall determine the esti-  
24 mated net reduction in expenditures under  
25 the fee schedule under this section with re-

1           spect to the year as a result of adjust-  
2           ments to the relative values established  
3           under this paragraph for misvalued codes.

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

12                 “(I) reduced expenditures attrib-  
13                 utable to such adjustments shall be  
14                 redistributed for the year in a budget  
15                 neutral manner in accordance with  
16                 subparagraph (B)(ii)(II); and

17                 “(II) the amount by which such  
18                 reduced expenditures exceeds the tar-  
19                 get for the year shall be treated as a  
20                 reduction in expenditures described in  
21                 clause (i) for the succeeding year, for  
22                 purposes of determining whether the  
23                 target has or has not been met under  
24                 this subparagraph with respect to that  
25                 year.

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

11           “(iv) TARGET RECAPTURE AMOUNT.—  
12 For purposes of clause (iii), the target re-  
13 capture amount is, with respect to a year,  
14 an amount equal to the difference be-  
15 tween—

16                   “(I) the target for the year; and  
17                   “(II) the estimated net reduction  
18 in expenditures determined under  
19 clause (i) for the year.

20           “(v) TARGET.—For purposes of this  
21 subparagraph, with respect to a year, the  
22 target is calculated as 0.5 percent of the  
23 estimated amount of expenditures under  
24 the fee schedule under this section for the  
25 year.”.



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

5                               “(VIII)     REDUCTIONS     FOR  
 6                               MISVALUED SERVICES IF TARGET NOT  
 7                               MET.—Effective for fee schedules be-  
 8                               ginning with 2015, reduced expendi-  
 9                               tures attributable to the application of  
 10                              the target recapture amount described  
 11                              in subparagraph (O)(iii).”.

12     (e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE  
 13     UNIT (RVU) REDUCTIONS.—

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

18                           “(7) PHASE-IN OF SIGNIFICANT RELATIVE  
 19     VALUE UNIT (RVU) REDUCTIONS.—Effective for fee  
 20     schedules established beginning with 2015, if the  
 21     total relative value units for a service for a year  
 22     would otherwise be decreased by an estimated  
 23     amount equal to or greater than 20 percent as com-  
 24     pared to the total relative value units for the pre-  
 25     vious year, the applicable adjustments in work, prac-

1        tice expense, and malpractice relative value units  
 2        shall be phased-in over a 2-year period.”.

3            (2)        CONFORMING        AMENDMENTS.—Section  
 4        1848(c)(2) of the Social Security Act (42 U.S.C.  
 5        1395w-4(c)(2)) is amended—

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

9            (B) in subparagraph (K)(iii)(VI)—

10            (i) by striking “provisions of subpara-  
 11            graph (B)(ii)(II)” and inserting “provi-  
 12            sions of subparagraph (B)(ii)(II) and para-  
 13            graph (7)”; and

14            (ii) by striking “under subparagraph  
 15            (B)(ii)(II)” and inserting “under subpara-  
 16            graph (B)(ii)(I)”.

17        (f)    AUTHORITY TO SMOOTH RELATIVE VALUES  
 18        WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of  
 19        the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)) is  
 20        amended—

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

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

1 (g) GAO STUDY AND REPORT ON RELATIVE VALUE  
2 SCALE UPDATE COMMITTEE.—

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

12 (2) REPORT.—Not later than 1 year after the  
13 date of the enactment of this Act, the Comptroller  
14 General shall submit to Congress a report containing  
15 the results of the study conducted under paragraph  
16 (1).

17 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-  
18 ITIES.—

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

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

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

8                   “(i) Each Metropolitan Statistical  
9                   Area (each in this paragraph referred to as  
10                  an ‘MSA’), as defined by the Director of  
11                  the Office of Management and Budget as  
12                  of December 31 of the previous year, shall  
13                  be a fee schedule area.

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

17           “(B) TRANSITION FOR MSAS PREVIOUSLY  
18           IN REST-OF-STATE PAYMENT LOCALITY OR IN  
19           LOCALITY 3.—

20                   “(i) IN GENERAL.—For services fur-  
21                  nished in California during a year begin-  
22                  ning with 2017 and ending with 2021 in  
23                  an MSA in a transition area (as defined in  
24                  subparagraph (D)), subject to subpara-  
25                  graph (C), the geographic index values to

1 be applied under this subsection for such  
2 year shall be equal to the sum of the fol-  
3 lowing:

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

13 “(II) MSA-BASED COMPO-  
14 NENT.—The MSA-based weighting  
15 factor (described in clause (iii)) for  
16 such year multiplied by the geographic  
17 index values computed for the fee  
18 schedule area under subparagraph (A)  
19 for the year (determined without re-  
20 gard to this subparagraph).

21 “(ii) OLD WEIGHTING FACTOR.—The  
22 old weighting factor described in this  
23 clause—

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

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

5 “(iii) MSA-BASED WEIGHTING FAC-  
6 TOR.—The MSA-based weighting factor  
7 described in this clause for a year is 1  
8 minus the old weighting factor under  
9 clause (ii) for that year.

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

19 “(D) TRANSITION AREA DEFINED.—In  
20 this paragraph, the term ‘transition area’  
21 means each of the following fee schedule areas  
22 for 2013:

23 “(i) The rest-of-State payment local-  
24 ity.

25 “(ii) Payment locality 3.

1           “(E) REFERENCES TO FEE SCHEDULE  
2           AREAS.—Effective for services furnished on or  
3           after January 1, 2017, for California, any ref-  
4           erence in this section to a fee schedule area  
5           shall be deemed a reference to a fee schedule  
6           area established in accordance with this para-  
7           graph.”.

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

13          (i) DISCLOSURE OF DATA USED TO ESTABLISH  
14          MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—  
15          The Secretary of Health and Human Services shall make  
16          publicly available the information used to establish the  
17          multiple procedure payment reduction policy to the profes-  
18          sional component of imaging services in the final rule pub-  
19          lished in the Federal Register, v. 77, n. 222, November  
20          16, 2012, pages 68891–69380 under the physician fee  
21          schedule under section 1848 of the Social Security Act (42  
22          U.S.C. 1395w–4).

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

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

5 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR  
6 CERTAIN IMAGING SERVICES.—

7 “(1) PROGRAM ESTABLISHED.—

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

17 “(B) APPROPRIATE USE CRITERIA DE-  
18 FINED.—In this subsection, the term ‘appro-  
19 priate use criteria’ means criteria, only devel-  
20 oped or endorsed by national professional med-  
21 ical specialty societies or other provider-led enti-  
22 ties, to assist ordering professionals and fur-  
23 nishing professionals in making the most appro-  
24 priate treatment decision for a specific clinical  
25 condition. To the extent feasible, such criteria  
26 shall be evidence-based.



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

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

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

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

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

21           “(E) ORDERING PROFESSIONAL DE-  
22           FINED.—In this subsection, the term ‘ordering  
23           professional’ means a physician (as defined in  
24           section 1861(r)) or a practitioner described in

1 section 1842(b)(18)(C) who orders an applica-  
2 ble imaging service for an individual.

3 “(F) FURNISHING PROFESSIONAL DE-  
4 FINED.—In this subsection, the term ‘fur-  
5 nishing professional’ means a physician (as de-  
6 fined in section 1861(r)) or a practitioner de-  
7 scribed in section 1842(b)(18)(C) who furnishes  
8 an applicable imaging service for an individual.

9 “(2) ESTABLISHMENT OF APPLICABLE APPRO-  
10 PRIATE USE CRITERIA.—

11 “(A) IN GENERAL.—Not later than No-  
12 vember 15, 2015, the Secretary shall through  
13 rulemaking, and in consultation with physi-  
14 cians, practitioners, and other stakeholders,  
15 specify applicable appropriate use criteria for  
16 applicable imaging services only from among  
17 appropriate use criteria developed or endorsed  
18 by national professional medical specialty soci-  
19 eties or other provider-led entities.

20 “(B) CONSIDERATIONS.—In specifying ap-  
21 plicable appropriate use criteria under subpara-  
22 graph (A), the Secretary shall take into account  
23 whether the criteria—

24 “(i) have stakeholder consensus;

1                   “(ii) are scientifically valid and evi-  
2                   dence based; and

3                   “(iii) are based on studies that are  
4                   published and reviewable by stakeholders.

5                   “(C) REVISIONS.—The Secretary shall re-  
6                   view, on an annual basis, the specified applica-  
7                   ble appropriate use criteria to determine if  
8                   there is a need to update or revise (as appro-  
9                   priate) such specification of applicable appro-  
10                  priate use criteria and make such updates or  
11                  revisions through rulemaking.

12                  “(D) TREATMENT OF MULTIPLE APPLICA-  
13                  BLE APPROPRIATE USE CRITERIA.—In the case  
14                  where the Secretary determines that more than  
15                  one appropriate use criteria applies with respect  
16                  to an applicable imaging service, the Secretary  
17                  shall permit one or more applicable appropriate  
18                  use criteria under this paragraph for the serv-  
19                  ice.

20                  “(3) MECHANISMS FOR CONSULTATION WITH  
21                  APPLICABLE APPROPRIATE USE CRITERIA.—

22                  “(A) IDENTIFICATION OF MECHANISMS TO  
23                  CONSULT WITH APPLICABLE APPROPRIATE USE  
24                  CRITERIA.—

1           “(i) IN GENERAL.—The Secretary  
2           shall specify qualified clinical decision sup-  
3           port mechanisms that could be used by or-  
4           dering professionals to consult with appli-  
5           cable appropriate use criteria for applicable  
6           imaging services.

7           “(ii) CONSULTATION.—The Secretary  
8           shall consult with physicians, practitioners,  
9           health care technology experts, and other  
10          stakeholders in specifying mechanisms  
11          under this paragraph.

12          “(iii) INCLUSION OF CERTAIN MECHA-  
13          NISMS.—Mechanisms specified under this  
14          paragraph may include any or all of the  
15          following that meet the requirements de-  
16          scribed in subparagraph (B)(ii):

17               “(I) Use of clinical decision sup-  
18               port modules in certified EHR tech-  
19               nology (as defined in section  
20               1848(o)(4)).

21               “(II) Use of private sector clin-  
22               ical decision support mechanisms that  
23               are independent from certified EHR  
24               technology, which may include use of  
25               clinical decision support mechanisms

1 available from medical specialty orga-  
2 nizations.

3 “(III) Use of a clinical decision  
4 support mechanism established by the  
5 Secretary.

6 “(B) QUALIFIED CLINICAL DECISION SUP-  
7 PORT MECHANISMS.—

8 “(i) IN GENERAL.—For purposes of  
9 this subsection, a qualified clinical decision  
10 support mechanism is a mechanism that  
11 the Secretary determines meets the re-  
12 quirements described in clause (ii).

13 “(ii) REQUIREMENTS.—The require-  
14 ments described in this clause are the fol-  
15 lowing:

16 “(I) The mechanism makes avail-  
17 able to the ordering professional appli-  
18 cable appropriate use criteria specified  
19 under paragraph (2) and the sup-  
20 porting documentation for the applica-  
21 ble imaging service ordered.

22 “(II) In the case where there are  
23 more than one applicable appropriate  
24 use criteria specified under such para-  
25 graph for an applicable imaging serv-

1 ice, the mechanism indicates the cri-  
2 teria that it uses for the service.

3 “(III) The mechanism determines  
4 the extent to which an applicable im-  
5 aging service ordered is consistent  
6 with the applicable appropriate use  
7 criteria so specified.

8 “(IV) The mechanism generates  
9 and provides to the ordering profes-  
10 sional a certification or documentation  
11 that documents that the qualified clin-  
12 ical decision support mechanism was  
13 consulted by the ordering professional.

14 “(V) The mechanism is updated  
15 on a timely basis to reflect revisions  
16 to the specification of applicable ap-  
17 propriate use criteria under such  
18 paragraph.

19 “(VI) The mechanism meets pri-  
20 vacy and security standards under ap-  
21 plicable provisions of law.

22 “(VII) The mechanism performs  
23 such other functions as specified by  
24 the Secretary, which may include a re-

1                   requirement to provide aggregate feed-  
2                   back to the ordering professional.

3                   “(C) LIST OF MECHANISMS FOR CON-  
4                   SULTATION WITH APPLICABLE APPROPRIATE  
5                   USE CRITERIA.—

6                   “(i) INITIAL LIST.—Not later than  
7                   April 1, 2016, the Secretary shall publish  
8                   a list of mechanisms specified under this  
9                   paragraph.

10                  “(ii) PERIODIC UPDATING OF LIST.—  
11                  The Secretary shall identify on an annual  
12                  basis the list of qualified clinical decision  
13                  support mechanisms specified under this  
14                  paragraph.

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

17                  “(A) CONSULTATION BY ORDERING PRO-  
18                  FESSIONAL.—Beginning with January 1, 2017,  
19                  subject to subparagraph (C), with respect to an  
20                  applicable imaging service ordered by an order-  
21                  ing professional that would be furnished in an  
22                  applicable setting and paid for under an appli-  
23                  cable payment system (as defined in subpara-  
24                  graph (D)), an ordering professional shall—

1 “(i) consult with a qualified decision  
2 support mechanism listed under paragraph  
3 (3)(C); and

4 “(ii) provide to the furnishing profes-  
5 sional the information described in clauses  
6 (i) through (iii) of subparagraph (B).

7 “(B) REPORTING BY FURNISHING PROFES-  
8 SIONAL.—Beginning with January 1, 2017,  
9 subject to subparagraph (C), with respect to an  
10 applicable imaging service furnished in an ap-  
11 plicable setting and paid for under an applica-  
12 ble payment system (as defined in subpara-  
13 graph (D)), payment for such service may only  
14 be made if the claim for the service includes the  
15 following:

16 “(i) Information about which qualified  
17 clinical decision support mechanism was  
18 consulted by the ordering professional for  
19 the service.

20 “(ii) Information regarding—

21 “(I) whether the service ordered  
22 would adhere to the applicable appro-  
23 priate use criteria specified under  
24 paragraph (2);



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

3 “(III) whether such criteria was  
4 not applicable to the service ordered.

5 “(iii) The national provider identifier  
6 of the ordering professional (if different  
7 from the furnishing professional).

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

11 “(i) EMERGENCY SERVICES.—An ap-  
12 plicable imaging service ordered for an in-  
13 dividual with an emergency medical condi-  
14 tion (as defined in section 1867(e)(1)).

15 “(ii) INPATIENT SERVICES.—An appli-  
16 cable imaging service ordered for an inpa-  
17 tient and for which payment is made under  
18 part A.

19 “(iii) ALTERNATIVE PAYMENT MOD-  
20 ELS.—An applicable imaging service or-  
21 dered by an ordering professional with re-  
22 spect to an individual attributed to an al-  
23 ternative payment model (as defined in  
24 section 1833(z)(3)(C)).

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

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

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

17                         “(ii) The prospective payment system  
18                         for hospital outpatient department services  
19                         under section 1833(t).

20                         “(iii) The ambulatory surgical center  
21                         payment systems under section 1833(i).

22                  “(5) IDENTIFICATION OF OUTLIER ORDERING  
23                  PROFESSIONALS.—

24                         “(A) IN GENERAL.—With respect to appli-  
25                         cable imaging services furnished beginning with

1           2017, the Secretary shall determine, on an an-  
2           nual basis, no more than five percent of the  
3           total number of ordering professionals who are  
4           outlier ordering professionals.

5           “(B)   OUTLIER   ORDERING   PROFES-  
6           SIONALS.—The determination of an outlier or-  
7           dering professional shall—

8                   “(i) be based on low adherence to ap-  
9                   plicable appropriate use criteria specified  
10                  under paragraph (2), which may be based  
11                  on comparison to other ordering profes-  
12                  sionals; and

13                  “(ii) include data for ordering profes-  
14                  sionals for whom prior authorization under  
15                  paragraph (6)(A) applies.

16           “(C) USE OF TWO YEARS OF DATA.—The  
17           Secretary shall use two years of data to identify  
18           outlier ordering professionals under this para-  
19           graph.

20           “(D) PROCESS.—The Secretary shall es-  
21           tablish a process for determining when an  
22           outlier ordering professional is no longer an  
23           outlier ordering professional.

24           “(E)   CONSULTATION   WITH   STAKE-  
25           HOLDERS.—The Secretary shall consult with

1 physicians, practitioners and other stakeholders  
2 in developing methods to identify outlier order-  
3 ing professionals under this paragraph.

4 “(6) PRIOR AUTHORIZATION FOR ORDERING  
5 PROFESSIONALS WHO ARE OUTLIERS.—

6 “(A) IN GENERAL.—Beginning January 1,  
7 2020, subject to paragraph (4)(C), with respect  
8 to services furnished during a year, the Sec-  
9 retary shall, for a period determined appro-  
10 priate by the Secretary, apply prior authoriza-  
11 tion for applicable imaging services that are or-  
12 dered by an outlier ordering professional identi-  
13 fied under paragraph (5).

14 “(B) APPROPRIATE USE CRITERIA IN  
15 PRIOR AUTHORIZATION.—In applying prior au-  
16 thorization under subparagraph (A), the Sec-  
17 retary shall utilize only the applicable appro-  
18 priate use criteria specified under this sub-  
19 section.

20 “(C) FUNDING.—For purposes of carrying  
21 out this paragraph, the Secretary shall provide  
22 for the transfer, from the Federal Supple-  
23 mentary Medical Insurance Trust Fund under  
24 section 1841, of \$5,000,000 to the Centers for  
25 Medicare & Medicaid Services Program Man-

1           agement Account for each of fiscal years 2019  
2           through 2021. Amounts transferred under the  
3           preceding sentence shall remain available until  
4           expended.

5           “(7) CONSTRUCTION.—Nothing in this sub-  
6           section shall be construed as granting the Secretary  
7           the authority to develop or initiate the development  
8           of clinical practice guidelines or appropriate use cri-  
9           teria.”.

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

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

19          (c) REPORT ON EXPERIENCE OF IMAGING APPRO-  
20 PRIATE USE CRITERIA PROGRAM.—Not later than 18  
21 months after the date of the enactment of this Act, the  
22 Comptroller General of the United States shall submit to  
23 Congress a report that includes a description of the extent  
24 to which appropriate use criteria could be used for other  
25 services under part B of title XVIII of the Social Security

1 Act (42 U.S.C. 1395j et seq.), such as radiation therapy  
2 and clinical diagnostic laboratory services.

3 **SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH**  
4 **ACCESS TO INFORMATION ON PHYSICIANS'**  
5 **SERVICES.**

6 (a) IN GENERAL.—The Secretary shall make publicly  
7 available on Physician Compare the information described  
8 in subsection (b) with respect to eligible professionals.

9 (b) INFORMATION DESCRIBED.—The following infor-  
10 mation, with respect to an eligible professional, is de-  
11 scribed in this subsection:

12 (1) Information on the number of services fur-  
13 nished by the eligible professional under part B of  
14 title XVIII of the Social Security Act (42 U.S.C.  
15 1395j et seq.), which may include information on the  
16 most frequent services furnished or groupings of  
17 services.

18 (2) Information on submitted charges and pay-  
19 ments for services under such part.

20 (3) A unique identifier for the eligible profes-  
21 sional that is available to the public, such as a na-  
22 tional provider identifier.

23 (c) SEARCHABILITY.—The information made avail-  
24 able under this section shall be searchable by at least the  
25 following:

1           (1) The specialty or type of the eligible profes-  
2           sional.

3           (2) Characteristics of the services furnished,  
4           such as volume or groupings of services.

5           (3) The location of the eligible professional.

6           (d) DISCLOSURE.—The information made available  
7           under this section shall indicate, where appropriate, that  
8           publicized information may not be representative of the  
9           eligible professional's entire patient population, the variety  
10          of services furnished by the eligible professional, or the  
11          health conditions of individuals treated.

12          (e) IMPLEMENTATION.—

13           (1) INITIAL IMPLEMENTATION.—Physician  
14           Compare shall include the information described in  
15           subsection (b)—

16           (A) with respect to physicians, by not later  
17           than July 1, 2015; and

18           (B) with respect to other eligible profes-  
19           sionals, by not later than July 1, 2016.

20           (2) ANNUAL UPDATING.—The information  
21           made available under this section shall be updated  
22           on Physician Compare not less frequently than on  
23           an annual basis.

24           (f) OPPORTUNITY TO REVIEW AND SUBMIT CORREC-  
25          TIONS.—The Secretary shall provide for an opportunity

1 for an eligible professional to review, and submit correc-  
 2 tions for, the information to be made public with respect  
 3 to the eligible professional under this section prior to such  
 4 information being made public.

5 (g) DEFINITIONS.—In this section:

6 (1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SEC-  
 7 RETARY.—The terms “eligible professional”, “physi-  
 8 cian”, and “Secretary” have the meaning given such  
 9 terms in section 10331(i) of Public Law 111–148.

10 (2) PHYSICIAN COMPARE.—The term “Physi-  
 11 cian Compare” means the Physician Compare Inter-  
 12 net website of the Centers for Medicare & Medicaid  
 13 Services (or a successor website).

14 **SEC. 8. EXPANDING AVAILABILITY OF MEDICARE DATA.**

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

17 (1) ADDITIONAL ANALYSES.—

18 (A) IN GENERAL.—Subject to subpara-  
 19 graph (B), to the extent consistent with appli-  
 20 cable information, privacy, security, and disclo-  
 21 sure laws (including paragraph (3)), notwith-  
 22 standing paragraph (4)(B) of section 1874(e) of  
 23 the Social Security Act (42 U.S.C. 1395kk(e))  
 24 and the second sentence of paragraph (4)(D) of  
 25 such section, beginning July 1, 2015, a quali-



1       fied entity may use the combined data described  
2       in paragraph (4)(B)(iii) of such section received  
3       by such entity under such section, and informa-  
4       tion derived from the evaluation described in  
5       such paragraph (4)(D), to conduct additional  
6       non-public analyses (as determined appropriate  
7       by the Secretary) and provide or sell such anal-  
8       yses to authorized users for non-public use (in-  
9       cluding for the purposes of assisting providers  
10      of services and suppliers to develop and partici-  
11      pate in quality and patient care improvement  
12      activities, including developing new models of  
13      care).

14               (B) LIMITATIONS WITH RESPECT TO ANAL-  
15      YSES.—

16               (i) EMPLOYERS.—Any analyses pro-  
17      vided or sold under subparagraph (A) to  
18      an employer described in paragraph  
19      (9)(A)(iii) may only be used by such em-  
20      ployer for purposes of providing health in-  
21      surance to employees and retirees of the  
22      employer.

23               (ii) HEALTH INSURANCE ISSUERS.—A  
24      qualified entity may not provide or sell an  
25      analysis to a health insurance issuer de-

scribed in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) ACCESS TO CERTAIN DATA.—

(A) ACCESS.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2015, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, in-

cluding for the purposes described in subparagraph (B).

(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) MEDICARE CLAIMS DATA MUST BE PROVIDED AT NO COST.—A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) PROTECTION OF INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individ-

1 ually identifies a patient of such provider or  
2 supplier, including with respect to items and  
3 services furnished to the patient by other pro-  
4 viders of services or suppliers.

5 (C) PROHIBITION ON USING ANALYSES OR  
6 DATA FOR MARKETING PURPOSES.—An author-  
7 ized user shall not use an analysis or data pro-  
8 vided or sold under paragraph (1) or (2) for  
9 marketing purposes.

10 (4) DATA USE AGREEMENT.—A qualified entity  
11 and an authorized user described in clauses (i), (ii),  
12 and (v) of paragraph (9)(A) shall enter into an  
13 agreement regarding the use of any data that the  
14 qualified entity is providing or selling to the author-  
15 ized user under paragraph (2). Such agreement shall  
16 describe the requirements for privacy and security of  
17 the data and, as determined appropriate by the Sec-  
18 retary, any prohibitions on using such data to link  
19 to other individually identifiable sources of informa-  
20 tion. If the authorized user is not a covered entity  
21 under the rules promulgated pursuant to the Health  
22 Insurance Portability and Accountability Act of  
23 1996, the agreement shall identify the relevant regu-  
24 lations, as determined by the Secretary, that the

1 user shall comply with as if it were acting in the ca-  
2 pacity of such a covered entity.

3 (5) NO REDISCLOSURE OF ANALYSES OR  
4 DATA.—

5 (A) IN GENERAL.—Except as provided in  
6 subparagraph (B), an authorized user that is  
7 provided or sold an analysis or data under  
8 paragraph (1) or (2) shall not redisclose or  
9 make public such analysis or data or any anal-  
10 ysis using such data.

11 (B) PERMITTED REDISCLOSURE.—A pro-  
12 vider of services or supplier that is provided or  
13 sold an analysis or data under paragraph (1) or  
14 (2) may, as determined by the Secretary, redis-  
15 close such analysis or data for the purposes of  
16 performance improvement and care coordination  
17 activities but shall not make public such anal-  
18 ysis or data or any analysis using such data.

19 (6) OPPORTUNITY FOR PROVIDERS OF SERV-  
20 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-  
21 fied entity providing or selling an analysis to an au-  
22 thorized user under paragraph (1), to the extent  
23 that such analysis would individually identify a pro-  
24 vider of services or supplier who is not being pro-  
25 vided or sold such analysis, such qualified entity

1 shall provide such provider or supplier with the op-  
2 portunity to appeal and correct errors in the manner  
3 described in section 1874(e)(4)(C)(ii) of the Social  
4 Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

5 (7) ASSESSMENT FOR A BREACH.—

6 (A) IN GENERAL.—In the case of a breach  
7 of a data use agreement under this section or  
8 section 1874(e) of the Social Security Act (42  
9 U.S.C. 1395kk(e)), the Secretary shall impose  
10 an assessment on the qualified entity both in  
11 the case of—

12 (i) an agreement between the Sec-  
13 retary and a qualified entity; and

14 (ii) an agreement between a qualified  
15 entity and an authorized user.

16 (B) ASSESSMENT.—The assessment under  
17 subparagraph (A) shall be an amount up to  
18 \$100 for each individual entitled to, or enrolled  
19 for, benefits under part A of title XVIII of the  
20 Social Security Act or enrolled for benefits  
21 under part B of such title—

22 (i) in the case of an agreement de-  
23 scribed in subparagraph (A)(i), for whom  
24 the Secretary provided data on to the  
25 qualified entity under paragraph (2); and

1 (ii) in the case of an agreement de-  
2 scribed in subparagraph (A)(ii), for whom  
3 the qualified entity provided data on to the  
4 authorized user under paragraph (2).

5 (C) DEPOSIT OF AMOUNTS COLLECTED.—  
6 Any amounts collected pursuant to this para-  
7 graph shall be deposited in Federal Supple-  
8 mentary Medical Insurance Trust Fund under  
9 section 1841 of the Social Security Act (42  
10 U.S.C. 1395t).

11 (8) ANNUAL REPORTS.—Any qualified entity  
12 that provides or sells an analysis or data under  
13 paragraph (1) or (2) shall annually submit to the  
14 Secretary a report that includes—

15 (A) a summary of the analyses provided or  
16 sold, including the number of such analyses, the  
17 number of purchasers of such analyses, and the  
18 total amount of fees received for such analyses;

19 (B) a description of the topics and pur-  
20 poses of such analyses;

21 (C) information on the entities who re-  
22 ceived the data under paragraph (2), the uses  
23 of the data, and the total amount of fees re-  
24 ceived for providing, selling, or sharing the  
25 data; and

1 (D) other information determined appro-  
2 priate by the Secretary.

3 (9) DEFINITIONS.—In this subsection and sub-  
4 section (b):

5 (A) AUTHORIZED USER.—The term “au-  
6 thorized user” means the following:

7 (i) A provider of services.

8 (ii) A supplier.

9 (iii) An employer (as defined in sec-  
10 tion 3(5) of the Employee Retirement In-  
11 surance Security Act of 1974).

12 (iv) A health insurance issuer (as de-  
13 fined in section 2791 of the Public Health  
14 Service Act).

15 (v) A medical society or hospital asso-  
16 ciation.

17 (vi) Any entity not described in  
18 clauses (i) through (v) that is approved by  
19 the Secretary (other than an employer or  
20 health insurance issuer not described in  
21 clauses (iii) and (iv), respectively, as deter-  
22 mined by the Secretary).

23 (B) PROVIDER OF SERVICES.—The term  
24 “provider of services” has the meaning given



1 such term in section 1861(u) of the Social Se-  
2 curity Act (42 U.S.C. 1395x(u)).

3 (C) QUALIFIED ENTITY.—The term “quali-  
4 fied entity” has the meaning given such term in  
5 section 1874(e)(2) of the Social Security Act  
6 (42 U.S.C. 1395kk(e)).

7 (D) SECRETARY.—The term “Secretary”  
8 means the Secretary of Health and Human  
9 Services.

10 (E) SUPPLIER.—The term “supplier” has  
11 the meaning given such term in section 1861(d)  
12 of the Social Security Act (42 U.S.C.  
13 1395x(d)).

14 (b) ACCESS TO MEDICARE DATA BY QUALIFIED  
15 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY  
16 IMPROVEMENT.—

17 (1) ACCESS.—

18 (A) IN GENERAL.—To the extent con-  
19 sistent with applicable information, privacy, se-  
20 curity, and disclosure laws, beginning July 1,  
21 2015, the Secretary shall, at the request of a  
22 qualified clinical data registry under section  
23 1848(m)(3)(E) of the Social Security Act (42  
24 U.S.C. 1395w–4(m)(3)(E)), provide the data  
25 described in subparagraph (B) (in a form and

1 manner determined to be appropriate) to such  
2 qualified clinical data registry for purposes of  
3 linking such data with clinical outcomes data  
4 and performing risk-adjusted, scientifically valid  
5 analyses and research to support quality im-  
6 provement or patient safety, provided that any  
7 public reporting of such analyses or research  
8 that identifies a provider of services or supplier  
9 shall only be conducted with the opportunity of  
10 such provider or supplier to appeal and correct  
11 errors in the manner described in subsection  
12 (a)(6).

13 (B) DATA DESCRIBED.—The data de-  
14 scribed in this subparagraph is—

15 (i) claims data under the Medicare  
16 program under title XVIII of the Social  
17 Security Act; and

18 (ii) if the Secretary determines appro-  
19 priate, claims data under the Medicaid  
20 program under title XIX of such Act and  
21 the State Children’s Health Insurance Pro-  
22 gram under title XXI of such Act.

23 (2) FEE.—Data described in paragraph (1)(B)  
24 shall be provided to a qualified clinical data registry  
25 under paragraph (1) at a fee equal to the cost of

1 providing such data. Any fee collected pursuant to  
2 the preceding sentence shall be deposited in the Cen-  
3 ters for Medicare & Medicaid Services Program  
4 Management Account.

5 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED  
6 ENTITIES.—Section 1874(e) of the Social Security Act  
7 (42 U.S.C. 1395kk(e)) is amended—

8 (1) in the subsection heading, by striking  
9 “MEDICARE”; and

10 (2) in paragraph (3)—

11 (A) by inserting after the first sentence the  
12 following new sentence: “Beginning July 1,  
13 2015, if the Secretary determines appropriate,  
14 the data described in this paragraph may also  
15 include standardized extracts (as determined by  
16 the Secretary) of claims data under titles XIX  
17 and XXI for assistance provided under such ti-  
18 tles for one or more specified geographic areas  
19 and time periods requested by a qualified enti-  
20 ty.”; and

21 (B) in the last sentence, by inserting “or  
22 under titles XIX or XXI” before the period at  
23 the end.

1 (d) REVISION OF PLACEMENT OF FEES.—Section  
 2 1874(e)(4)(A) of the Social Security Act (42 U.S.C.  
 3 1395kk(e)(4)(A)) is amended, in the second sentence—

4 (1) by inserting “, for periods prior to July 1,  
 5 2015,” after “deposited”; and

6 (2) by inserting the following before the period  
 7 at the end: “, and, beginning July 1, 2015, into the  
 8 Centers for Medicare & Medicaid Services Program  
 9 Management Account”.

10 **SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER**  
 11 **PROVISIONS.**

12 (a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-  
 13 OUT TO PRIVATE CONTRACT.—

14 (1) INDEFINITE, CONTINUING AUTOMATIC EX-  
 15 TENSION OF OPT OUT ELECTION.—

16 (A) IN GENERAL.—Section 1802(b)(3) of  
 17 the Social Security Act (42 U.S.C. 1395a(b)(3))  
 18 is amended—

19 (i) in subparagraph (B)(ii), by strik-  
 20 ing “during the 2-year period beginning on  
 21 the date the affidavit is signed” and insert-  
 22 ing “during the applicable 2-year period  
 23 (as defined in subparagraph (D))”;

24 (ii) in subparagraph (C), by striking  
 25 “during the 2-year period described in sub-

1 paragraph (B)(ii)” and inserting “during  
2 the applicable 2-year period”; and

3 (iii) by adding at the end the fol-  
4 lowing new subparagraph:

5 “(D) APPLICABLE 2-YEAR PERIODS FOR  
6 EFFECTIVENESS OF AFFIDAVITS.—In this sub-  
7 section, the term ‘applicable 2-year period’  
8 means, with respect to an affidavit of a physi-  
9 cian or practitioner under subparagraph (B),  
10 the 2-year period beginning on the date the af-  
11 fidavit is signed and includes each subsequent  
12 2-year period unless the physician or practi-  
13 tioner involved provides notice to the Secretary  
14 (in a form and manner specified by the Sec-  
15 retary), not later than 30 days before the end  
16 of the previous 2-year period, that the physician  
17 or practitioner does not want to extend the ap-  
18 plication of the affidavit for such subsequent 2-  
19 year period.”.

20 (B) EFFECTIVE DATE.—The amendments  
21 made by subparagraph (A) shall apply to affi-  
22 davits entered into on or after the date that is  
23 60 days after the date of the enactment of this  
24 Act.

1           (2) PUBLIC AVAILABILITY OF INFORMATION ON  
2           OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section  
3           1802(b) of the Social Security Act (42 U.S.C.  
4           1395a(b)) is amended—

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

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

11                   (B) by redesignating paragraph (5) as  
12          paragraph (6); and

13                   (C) by inserting after paragraph (4) the  
14          following new paragraph:

15                   “(5) POSTING OF INFORMATION ON OPT-OUT  
16          PHYSICIANS AND PRACTITIONERS.—

17                   “(A) IN GENERAL.—Beginning not later  
18          than February 1, 2015, the Secretary shall  
19          make publicly available through an appropriate  
20          publicly accessible website of the Department of  
21          Health and Human Services information on the  
22          number and characteristics of opt-out physi-  
23          cians and practitioners and shall update such  
24          information on such website not less often than  
25          annually.

1 “(B) INFORMATION TO BE INCLUDED.—

2 The information to be made available under  
3 subparagraph (A) shall include at least the fol-  
4 lowing with respect to opt-out physicians and  
5 practitioners:

6 “(i) Their number.

7 “(ii) Their physician or professional  
8 specialty or other designation.

9 “(iii) Their geographic distribution.

10 “(iv) The timing of their becoming  
11 opt-out physicians and practitioners, rel-  
12 ative to when they first entered practice  
13 and with respect to applicable 2-year peri-  
14 ods.

15 “(v) The proportion of such physi-  
16 cians and practitioners who billed for  
17 emergency or urgent care services.”.

18 (b) GAINSHARING STUDY AND REPORT.—Not later  
19 than 6 months after the date of the enactment of this Act,  
20 the Secretary of Health and Human Services, in consulta-  
21 tion with the Inspector General of the Department of  
22 Health and Human Services, shall submit to Congress a  
23 report with legislative recommendations to amend existing  
24 fraud and abuse laws, through exceptions, safe harbors,  
25 or other narrowly targeted provisions, to permit

1 gainsharing or similar arrangements between physicians  
2 and hospitals that improve care while reducing waste and  
3 increasing efficiency. The report shall—

4           (1) consider whether such provisions should  
5       apply to ownership interests, compensation arrange-  
6       ments, or other relationships;

7           (2) describe how the recommendations address  
8       accountability, transparency, and quality, including  
9       how best to limit inducements to stint on care, dis-  
10      charge patients prematurely, or otherwise reduce or  
11      limit medically necessary care; and

12          (3) consider whether a portion of any savings  
13      generated by such arrangements should accrue to  
14      the Medicare program under title XVIII of the So-  
15      cial Security Act.

16      (c) PROMOTING INTEROPERABILITY OF ELECTRONIC  
17      HEALTH RECORD SYSTEMS.—

18           (1) RECOMMENDATIONS FOR ACHIEVING WIDE-  
19      SPREAD EHR INTEROPERABILITY.—

20           (A) OBJECTIVE.—As a consequence of a  
21      significant Federal investment in the implemen-  
22      tation of health information technology through  
23      the Medicare and Medicaid EHR incentive pro-  
24      grams, Congress declares it a national objective  
25      to achieve widespread exchange of health infor-



1 mation through interoperable certified EHR  
2 technology nationwide by December 31, 2017.

3 (B) DEFINITIONS.—In this paragraph:

4 (i) WIDESPREAD INTEROPER-  
5 ABILITY.—The term “widespread inter-  
6 operability” means interoperability between  
7 certified EHR technology systems em-  
8 ployed by meaningful EHR users under  
9 the Medicare and Medicaid EHR incentive  
10 programs and other clinicians and health  
11 care providers on a nationwide basis.

12 (ii) INTEROPERABILITY.—The term  
13 “interoperability” means the ability of two  
14 or more health information systems or  
15 components to exchange clinical and other  
16 information and to use the information  
17 that has been exchanged using common  
18 standards as to provide access to longitu-  
19 dinal information for health care providers  
20 in order to facilitate coordinated care and  
21 improved patient outcomes.

22 (C) ESTABLISHMENT OF METRICS.—Not  
23 later than July 1, 2015, and in consultation  
24 with stakeholders, the Secretary shall establish  
25 metrics to be used to determine if and to the

1 extent that the objective described in subpara-  
2 graph (A) has been achieved.

3 (D) RECOMMENDATIONS IF OBJECTIVE  
4 NOT ACHIEVED.—If the Secretary of Health  
5 and Human Services determines that the objec-  
6 tive described in subparagraph (A) has not been  
7 achieved by December 31, 2017, then the Sec-  
8 retary shall submit to Congress a report, by not  
9 later than December 31, 2018, that identifies  
10 barriers to such objective and recommends ac-  
11 tions that the Federal Government can take to  
12 achieve such objective. Such recommended ac-  
13 tions may include recommendations—

14 (i) to adjust payments for not being  
15 meaningful EHR users under the Medicare  
16 EHR incentive programs; and

17 (ii) for criteria for decertifying cer-  
18 tified EHR technology products.

19 (2) PREVENTING BLOCKING THE SHARING OF  
20 INFORMATION.—

21 (A) FOR MEANINGFUL EHR PROFES-  
22 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-  
23 cial Security Act (42 U.S.C. 1395w-  
24 4(o)(2)(A)(ii)) is amended by inserting before  
25 the period at the end the following: “, and the

1 professional demonstrates (through a process  
2 specified by the Secretary, such as the use of an  
3 attestation) that the professional has not know-  
4 ingly and willfully taken any action to limit or  
5 restrict the compatibility or interoperability of  
6 the certified EHR technology”.

7 (B) FOR MEANINGFUL EHR HOSPITALS.—  
8 Section 1886(n)(3)(A)(ii) of the Social Security  
9 Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amend-  
10 ed by inserting before the period at the end the  
11 following: “, and the hospital demonstrates  
12 (through a process specified by the Secretary,  
13 such as the use of an attestation) that the hos-  
14 pital has not knowingly and willfully taken any  
15 action to limit or restrict the compatibility or  
16 interoperability of the certified EHR tech-  
17 nology”.

18 (C) EFFECTIVE DATE.—The amendments  
19 made by this subsection shall apply to meaning-  
20 ful EHR users as of the date that is one year  
21 after the date of the enactment of this Act.

22 (3) STUDY AND REPORT ON THE FEASIBILITY  
23 OF ESTABLISHING A WEBSITE TO COMPARE CER-  
24 TIFIED EHR TECHNOLOGY PRODUCTS.—

1           (A) STUDY.—The Secretary shall conduct  
2           a study to examine the feasibility of estab-  
3           lishing mechanisms that includes aggregated re-  
4           sults of surveys of meaningful EHR users on  
5           the functionality of certified EHR technology  
6           products to enable such users to directly com-  
7           pare the functionality and other features of  
8           such products. Such information may be made  
9           available through contracts with physician, hos-  
10          pital, or other organizations that maintain such  
11          comparative information.

12          (B) REPORT.—Not later than 1 year after  
13          the date of the enactment of this Act, the Sec-  
14          retary shall submit to Congress a report on the  
15          website. The report shall include information on  
16          the benefits of, and resources needed to develop  
17          and maintain, such a website.

18          (4) DEFINITIONS.—In this subsection:

19               (A) The term “certified EHR technology”  
20               has the meaning given such term in section  
21               1848(o)(4) of the Social Security Act (42  
22               U.S.C. 1395w–4(o)(4)).

23               (B) The term “meaningful EHR user” has  
24               the meaning given such term under the Medi-  
25               care EHR incentive programs.

1 (C) The term “Medicare and Medicaid  
2 EHR incentive programs” means—

3 (i) in the case of the Medicare pro-  
4 gram under title XVIII of the Social Secu-  
5 rity Act, the incentive programs under sec-  
6 tion 1814(l)(3), section 1848(o), sub-  
7 sections (l) and (m) of section 1853, and  
8 section 1886(n) of the Social Security Act  
9 (42 U.S.C. 1395f(l)(3), 1395w-4(o),  
10 1395w-23, 1395ww(n)); and

11 (ii) in the case of the Medicaid pro-  
12 gram under title XIX of such Act, the in-  
13 centive program under subsections  
14 (a)(3)(F) and (t) of section 1903 of such  
15 Act (42 U.S.C. 1396b).

16 (D) The term “Secretary” means the Sec-  
17 retary of Health and Human Services.

18 (d) GAO STUDIES AND REPORTS ON THE USE OF  
19 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-  
20 MOTE PATIENT MONITORING SERVICES.—

21 (1) STUDY ON TELEHEALTH SERVICES.—The  
22 Comptroller General of the United States shall con-  
23 duct a study on the following:

24 (A) How the definition of telehealth across  
25 various Federal programs and Federal efforts

1 can inform the use of telehealth in the Medicare  
2 program under title XVIII of the Social Secu-  
3 rity Act (42 U.S.C. 1395 et seq.).

4 (B) Issues that can facilitate or inhibit the  
5 use of telehealth under the Medicare program  
6 under such title, including oversight and profes-  
7 sional licensure, changing technology, privacy  
8 and security, infrastructure requirements, and  
9 varying needs across urban and rural areas.

10 (C) Potential implications of greater use of  
11 telehealth with respect to payment and delivery  
12 system transformations under the Medicare  
13 program under such title XVIII and the Med-  
14 icaid program under title XIX of such Act (42  
15 U.S.C. 1396 et seq.).

16 (D) How the Centers for Medicare & Med-  
17 icaid Services conducts oversight of payments  
18 made under the Medicare program under such  
19 title XVIII to providers for telehealth services.

20 (2) STUDY ON REMOTE PATIENT MONITORING  
21 SERVICES.—

22 (A) IN GENERAL.—The Comptroller Gen-  
23 eral of the United States shall conduct a  
24 study—

1 (i) of the dissemination of remote pa-  
2 tient monitoring technology in the private  
3 health insurance market;

4 (ii) of the financial incentives in the  
5 private health insurance market relating to  
6 adoption of such technology;

7 (iii) of the barriers to adoption of  
8 such services under the Medicare program  
9 under title XVIII of the Social Security  
10 Act;

11 (iv) that evaluates the patients, condi-  
12 tions, and clinical circumstances that could  
13 most benefit from remote patient moni-  
14 toring services; and

15 (v) that evaluates the challenges re-  
16 lated to establishing appropriate valuation  
17 for remote patient monitoring services  
18 under the Medicare physician fee schedule  
19 under section 1848 of the Social Security  
20 Act (42 U.S.C. 1395w-4) in order to accu-  
21 rately reflect the resources involved in fur-  
22 nishing such services.

23 (B) DEFINITIONS.—For purposes of this  
24 paragraph:

1 (i) REMOTE PATIENT MONITORING  
2 SERVICES.—The term “remote patient  
3 monitoring services” means services fur-  
4 nished through remote patient monitoring  
5 technology.

6 (ii) REMOTE PATIENT MONITORING  
7 TECHNOLOGY.—The term “remote patient  
8 monitoring technology” means a coordi-  
9 nated system that uses one or more home-  
10 based or mobile monitoring devices that  
11 automatically transmit vital sign data or  
12 information on activities of daily living and  
13 may include responses to assessment ques-  
14 tions collected on the devices wirelessly or  
15 through a telecommunications connection  
16 to a server that complies with the Federal  
17 regulations (concerning the privacy of indi-  
18 vidually identifiable health information)  
19 promulgated under section 264(c) of the  
20 Health Insurance Portability and Account-  
21 ability Act of 1996, as part of an estab-  
22 lished plan of care for that patient that in-  
23 cludes the review and interpretation of that  
24 data by a health care professional.



1           (3) REPORTS.—Not later than 24 months after  
2           the date of the enactment of this Act, the Comp-  
3           troller General shall submit to Congress—

4                   (A) a report containing the results of the  
5                   study conducted under paragraph (1); and

6                   (B) a report containing the results of the  
7                   study conducted under paragraph (2).

8           A report required under this paragraph shall be sub-  
9           mitted together with recommendations for such leg-  
10          islation and administrative action as the Comptroller  
11          General determines appropriate. The Comptroller  
12          General may submit one report containing the re-  
13          sults described in subparagraphs (A) and (B) and  
14          the recommendations described in the previous sen-  
15          tence.

16          (e)    RULE    OF    CONSTRUCTION    REGARDING  
17   HEALTHCARE PROVIDER STANDARDS OF CARE.—

18                  (1) MAINTENANCE OF STATE STANDARDS.—

19          The development, recognition, or implementation of  
20          any guideline or other standard under any Federal  
21          health care provision shall not be construed—

22                   (A) to establish the standard of care or  
23                   duty of care owed by a health care provider to  
24                   a patient in any medical malpractice or medical  
25                   product liability action or claim; or

1 (B) to preempt any standard of care or  
2 duty of care, owed by a health care provider to  
3 a patient, duly established under State or com-  
4 mon law.

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

7 (A) FEDERAL HEALTH CARE PROVISION.—  
8 The term “Federal health care provision”  
9 means any provision of the Patient Protection  
10 and Affordable Care Act (Public Law 111–  
11 148), title I or subtitle B of title II of the  
12 Health Care and Education Reconciliation Act  
13 of 2010 (Public Law 111–152), or title XVIII  
14 or XIX of the Social Security Act.

15 (B) HEALTH CARE PROVIDER.—The term  
16 “health care provider” means any individual or  
17 entity—

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

21 (ii) required to be so licensed, reg-  
22 istered, or certified but that is exempted  
23 by other statute or regulation.

24 (C) MEDICAL MALPRACTICE OR MEDICAL  
25 PRODUCT LIABILITY ACTION OR CLAIM.—The

1 term “medical malpractice or medical product  
2 liability action or claim” means a medical mal-  
3 practice action or claim (as defined in section  
4 431(7) of the Health Care Quality Improve-  
5 ment Act of 1986 (42 U.S.C. 11151(7))) and  
6 includes a liability action or claim relating to a  
7 health care provider’s prescription or provision  
8 of a drug, device, or biological product (as such  
9 terms are defined in section 201 of the Federal  
10 Food, Drug, and Cosmetic Act or section 351  
11 of the Public Health Service Act).

12 (D) STATE.—The term “State” includes  
13 the District of Columbia, Puerto Rico, and any  
14 other commonwealth, possession, or territory of  
15 the United States.

16 (3) PRESERVATION OF STATE LAW.—No provi-  
17 sion of the Patient Protection and Affordable Care  
18 Act (Public Law 111–148), title I or subtitle B of  
19 title II of the Health Care and Education Reconcili-  
20 ation Act of 2010 (Public Law 111–152), or title  
21 XVIII or XIX of the Social Security Act shall be  
22 construed to preempt any State or common law gov-  
23 erning medical professional or medical product liabil-  
24 ity actions or claims.

1 **SEC. 10. DELAY IN IMPLEMENTATION OF PENALTY FOR**  
2 **FAILURE TO COMPLY WITH INDIVIDUAL**  
3 **HEALTH INSURANCE MANDATE.**

4 (a) IN GENERAL.—Section 5000A(c) of the Internal  
5 Revenue Code of 1986 is amended by adding at the end  
6 the following new paragraph:

7 “(5) DELAY IN IMPLEMENTATION OF PEN-  
8 ALTY.—Notwithstanding any other provision of this  
9 subsection, the monthly penalty amount with respect  
10 to any taxpayer for any month beginning before  
11 January 1, 2019, shall be zero.”.

12 (b) DELAY OF CERTAIN PHASE INS AND INDEX-  
13 ING.—

14 (1) PHASE IN OF PERCENTAGE OF INCOME LIM-  
15 ITATION.—Section 5000A(c)(2)(B) of such Code is  
16 amended—

17 (A) by striking “2014” in clause (i) and  
18 inserting “2019”, and

19 (B) by striking “2015” in clauses (ii) and  
20 (iii) and inserting “2020”.

21 (2) PHASE IN OF APPLICABLE DOLLAR  
22 AMOUNT.—Section 5000A(c)(3)(B) of such Code is  
23 amended—

24 (A) by striking “2014” and inserting  
25 “2019”, and

1 (B) by striking “2015” (before amendment  
 2 by subparagraph (A)) and inserting “2020”.

3 (3) INDEXING OF APPLICABLE DOLLAR  
 4 AMOUNT.—Section 5000A(c)(3)(D) of such Code is  
 5 amended—

6 (A) by striking “2016” in the matter pre-  
 7 ceding clause (i) and inserting “2021”, and

8 (B) by striking “2015” in clause (ii) and  
 9 inserting “2020”.

10 (4) INDEXING OF EXEMPTION BASED ON  
 11 HOUSEHOLD INCOME.—Section 5000A(e)(1)(D) of  
 12 such Code is amended—

13 (A) by striking “2014” (before amendment  
 14 by subparagraph (B)) and inserting “2019”,  
 15 and

16 (B) by striking “2013” and inserting  
 17 “2018”.

18 (c) EFFECTIVE DATE.—The amendments made by  
 19 this section shall apply to months beginning after Decem-  
 20 ber 31, 2013.

Passed the House of Representatives March 14,  
 2014.

Attest:

*Clerk.*

113<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 4015

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## AN ACT

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.