

114TH CONGRESS  
1ST SESSION

# S. 810

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

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## IN THE SENATE OF THE UNITED STATES

MARCH 19, 2015

Mr. HATCH introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

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

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “SGR Repeal and Medicare Provider Payment Moderniza-  
6 tion Act of 2015”.

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

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

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

4 (a) STABILIZING FEE UPDATES.—

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

8 (A) in subsection (d)—

9 (i) in paragraph (1)(A)—

10 (I) by inserting “and ending with  
 11 2025” after “beginning with 2001”;  
 12 and

13 (II) by inserting “or a subse-  
 14 quent paragraph” after “paragraph  
 15 (4)”; and

16 (ii) in paragraph (4)—

17 (I) in the heading, by inserting  
 18 “AND ENDING WITH 2014” after  
 19 “YEARS BEGINNING WITH 2001”; and

1 (II) in subparagraph (A), by in-  
 2 serting “and ending with 2014” after  
 3 “a year beginning with 2001”; and

4 (B) in subsection (f)—

5 (i) in paragraph (1)(B), by inserting  
 6 “through 2014” after “of each succeeding  
 7 year”; and

8 (ii) in paragraph (2), in the matter  
 9 preceding subparagraph (A), by inserting  
 10 “and ending with 2014” after “beginning  
 11 with 2000”.

12 (2) UPDATE OF RATES FOR 2015 AND SUBSE-  
 13 QUENT YEARS.—Subsection (d) of section 1848 of  
 14 the Social Security Act (42 U.S.C. 1395w-4) is  
 15 amended—

16 (A) in paragraph (1)(A), by adding at the  
 17 end the following: “There shall be two separate  
 18 conversion factors for each year beginning with  
 19 2026, one for items and services furnished by  
 20 a qualifying APM participant (as defined in  
 21 section 1833(z)(2)) (referred to in this sub-  
 22 section as the ‘qualifying APM conversion fac-  
 23 tor’) and the other for other items and services  
 24 (referred to in this subsection as the ‘nonquali-  
 25 fying APM conversion factor’), equal to the re-

spective conversion factor for the previous year  
 (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.”;

(B) in paragraph (1)(D), by inserting “(or, beginning with 2026, applicable conversion factor)” after “single conversion factor”; and

(C) by striking paragraph (16) and inserting the following new paragraphs:

“(16) UPDATE FOR JANUARY THROUGH JUNE OF 2015.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

“(17) UPDATE FOR JULY THROUGH DECEMBER OF 2015.—The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

1           “(18) UPDATE FOR 2016 THROUGH 2019.—The  
 2           update to the single conversion factor established in  
 3           paragraph (1)(C) for 2016 and each subsequent  
 4           year through 2019 shall be 0.5 percent.

5           “(19) UPDATE FOR 2020 THROUGH 2025.—The  
 6           update to the single conversion factor established in  
 7           paragraph (1)(C) for 2020 and each subsequent  
 8           year through 2025 shall be zero percent.

9           “(20) UPDATE FOR 2026 AND SUBSEQUENT  
 10          YEARS.—For 2026 and each subsequent year, the  
 11          update to the qualifying APM conversion factor es-  
 12          tablished under paragraph (1)(A) is 1.0 percent, and  
 13          the update to the nonqualifying APM conversion fac-  
 14          tor established under such paragraph is 0.5 per-  
 15          cent.”.

16          (3) MEDPAC REPORTS.—

17                (A) INITIAL REPORT.—Not later than July  
 18                1, 2017, the Medicare Payment Advisory Com-  
 19                mission shall submit to Congress a report on  
 20                the relationship between—

21                       (i) physician and other health profes-  
 22                       sional utilization and expenditures (and the  
 23                       rate of increase of such utilization and ex-  
 24                       penditures) of items and services for which  
 25                       payment is made under section 1848 of the

1 Social Security Act (42 U.S.C. 1395w–4);

2 and

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

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

13 (B) FINAL REPORT.—Not later than July  
14 1, 2021, the Medicare Payment Advisory Com-  
15 mission shall submit to Congress a report on  
16 the relationship described in subparagraph (A),  
17 including the results determined from applying  
18 the methodology included in the report sub-  
19 mitted under such subparagraph.

20 (C) REPORT ON UPDATE TO PHYSICIANS’  
21 SERVICES UNDER MEDICARE.—Not later than  
22 July 1, 2019, the Medicare Payment Advisory  
23 Commission shall submit to Congress a report  
24 on—

(i) the payment update for professional services applied under the Medicare program under title XVIII of the Social Security Act for the period of years 2015 through 2019;

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

(iii) the effect of such update on ensuring a sufficient number of providers to maintain access to care by Medicare beneficiaries; and

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

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

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

(A) SUNSETTING SEPARATE MEANINGFUL USE PAYMENT ADJUSTMENTS.—Section

1 1848(a)(7)(A) of the Social Security Act (42  
 2 U.S.C. 1395w-4(a)(7)(A)) is amended—

3 (i) in clause (i), by striking “2015 or  
 4 any subsequent payment year” and insert-  
 5 ing “each of 2015 through 2018”;

6 (ii) in clause (ii)(III), by striking  
 7 “each subsequent year” and inserting  
 8 “2018”; and

9 (iii) in clause (iii)—

10 (I) in the heading, by striking  
 11 “AND SUBSEQUENT YEARS”;

12 (II) by striking “and each subse-  
 13 quent year”; and

14 (III) by striking “, but in no case  
 15 shall the applicable percent be less  
 16 than 95 percent”.

17 (B) CONTINUATION OF MEANINGFUL USE  
 18 DETERMINATIONS FOR MIPS.—Section  
 19 1848(o)(2) of the Social Security Act (42  
 20 U.S.C. 1395w-4(o)(2)) is amended—

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

23 (I) by striking “For purposes of  
 24 paragraph (1), an” and inserting  
 25 “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 2019 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 “2015 or any subsequent year” and inserting “each of 2015 through 2018”; and

(ii) in clause (ii)(II), by striking “and each subsequent year” and inserting “, 2017, and 2018”.

(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 Pub-

1                   lic Law 111–148 as paragraph (8);  
 2                   and

3                   (II) by adding at the end the fol-  
 4                   lowing new paragraph:

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

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

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

14                   (3) VALUE-BASED PAYMENTS.—

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

20                   “(iii) APPLICATION.—The Secretary  
 21                   shall apply the payment modifier estab-  
 22                   lished under this subsection for items and  
 23                   services furnished on or after January 1,  
 24                   2015, with respect to specific physicians  
 25                   and groups of physicians the Secretary de-

1 termines appropriate, and for services fur-  
 2 nished on or after January 1, 2017, with  
 3 respect to all physicians and groups of  
 4 physicians. Such payment modifier shall  
 5 not be applied for items and services fur-  
 6 nished on or after January 1, 2019.”.

7 (B) CONTINUATION OF VALUE-BASED PAY-  
 8 MENT MODIFIER MEASURES FOR MIPS.—Section  
 9 1848(p) of the Social Security Act (42 U.S.C.  
 10 1395w–4(p)) is amended—

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

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

18 (ii) in paragraph (3), by adding at the  
 19 end the following: “With respect to 2019  
 20 and each subsequent year, the Secretary  
 21 shall, in accordance with subsection  
 22 (q)(1)(F), carry out this paragraph for  
 23 purposes of subsection (q).”.

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

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

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

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the ‘MIPS’) under which the Secretary shall—

“(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

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

“(iii) use such composite performance score of the MIPS eligible professional for a performance period for a year to deter-

mine and apply a MIPS adjustment factor  
(and, as applicable, an additional MIPS  
adjustment factor) under paragraph (6) to  
the professional for the year.

Notwithstanding subparagraph (C)(ii), under  
the MIPS, the Secretary shall permit any eligi-  
ble professional (as defined in subsection  
(k)(3)(B)) to report on applicable measures and  
activities described in paragraph (2)(B).

“(B) PROGRAM IMPLEMENTATION.—The  
MIPS shall apply to payments for items and  
services furnished on or after January 1, 2019.

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

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

“(I) for the first and second  
years for which the MIPS applies to  
payments (and for the performance  
period for such first and second year),  
a physician (as defined in section  
1861(r)), a physician assistant, nurse  
practitioner, and clinical nurse spe-

1 cialist (as such terms are defined in  
 2 section 1861(aa)(5)), a certified reg-  
 3 istered nurse anesthetist (as defined  
 4 in section 1861(bb)(2)), and a group  
 5 that includes such professionals; and

6 “(II) for the third year for which  
 7 the MIPS applies to payments (and  
 8 for the performance period for such  
 9 third year) and for each succeeding  
 10 year (and for the performance period  
 11 for each such year), the professionals  
 12 described in subclause (I), such other  
 13 eligible professionals (as defined in  
 14 subsection (k)(3)(B)) as specified by  
 15 the Secretary, and a group that in-  
 16 cludes such professionals.

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

22 “(I) is a qualifying APM partici-  
 23 pant (as defined in section  
 24 1833(z)(2));

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

12 “(III) for the performance period  
 13 with respect to such year, does not ex-  
 14 ceed the low-volume threshold meas-  
 15 urement selected under clause (iv).

16 “(iii) PARTIAL QUALIFYING APM PAR-  
 17 TICIPANT.—For purposes of this subpara-  
 18 graph, the term ‘partial qualifying APM  
 19 participant’ means, with respect to a year,  
 20 an eligible professional for whom the Sec-  
 21 retary determines the minimum payment  
 22 percentage (or percentages), as applicable,  
 23 described in paragraph (2) of section  
 24 1833(z) for such year have not been satis-  
 25 fied, but who would be considered a quali-



1           fying APM participant (as defined in such  
2           paragraph) for such year if—

3                   “(I) with respect to 2019 and  
4                   2020, the reference in subparagraph  
5                   (A) of such paragraph to 25 percent  
6                   was instead a reference to 20 percent;

7                   “(II) with respect to 2021 and  
8                   2022—

9                           “(aa) the reference in sub-  
10                          paragraph (B)(i) of such para-  
11                          graph to 50 percent was instead  
12                          a reference to 40 percent; and

13                           “(bb) the references in sub-  
14                          paragraph (B)(ii) of such para-  
15                          graph to 50 percent and 25 per-  
16                          cent of such paragraph were in-  
17                          stead references to 40 percent  
18                          and 20 percent, respectively; and

19                   “(III) with respect to 2023 and  
20                   subsequent years—

21                           “(aa) the reference in sub-  
22                          paragraph (C)(i) of such para-  
23                          graph to 75 percent was instead  
24                          a reference to 50 percent; and

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

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

13 “(I) The minimum number (as  
14 determined by the Secretary) of indi-  
15 viduals enrolled under this part who  
16 are treated by the eligible professional  
17 for the performance period involved.

18 “(II) The minimum number (as  
19 determined by the Secretary) of items  
20 and services furnished to individuals  
21 enrolled under this part by such pro-  
22 fessional for such performance period.

23 “(III) The minimum amount (as  
24 determined by the Secretary) of al-  
25 lowed charges billed by such profes-

1           sional under this part for such per-  
2           formance period.

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

17          “(vi) CLARIFICATION.—In the case of  
18          items and services furnished during a year  
19          by an individual who is not a MIPS eligible  
20          professional (including pursuant to clauses  
21          (ii) and (v)) with respect to a year, in no  
22          case shall a MIPS adjustment factor (or  
23          additional MIPS adjustment factor) under  
24          paragraph (6) apply to such individual for  
25          such year.

1 “(vii) PARTIAL QUALIFYING APM PAR-  
2 TICIPANT CLARIFICATIONS.—

3 “(I) TREATMENT AS MIPS ELIGI-  
4 BLE PROFESSIONAL.—In the case of  
5 an eligible professional who is a par-  
6 tial qualifying APM participant, with  
7 respect to a year, and who, for the  
8 performance period for such year, re-  
9 ports on applicable measures and ac-  
10 tivities described in paragraph (2)(B)  
11 that are required to be reported by  
12 such a professional under the MIPS,  
13 such eligible professional is considered  
14 to be a MIPS eligible professional  
15 with respect to such year.

16 “(II) NOT ELIGIBLE FOR QUALI-  
17 FYING APM PARTICIPANT PAY-  
18 MENTS.—In no case shall an eligible  
19 professional who is a partial quali-  
20 fying APM participant, with respect  
21 to a year, be considered a qualifying  
22 APM participant (as defined in para-  
23 graph (2) of section 1833(z)) for such  
24 year or be eligible for the additional

1 payment under paragraph (1) of such  
2 section for such year.

3 “(D) APPLICATION TO GROUP PRAC-  
4 TICES.—

5 “(i) IN GENERAL.—Under the MIPS:

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

16 “(II) OTHER PERFORMANCE CAT-  
17 EGORIES.—The Secretary may estab-  
18 lish and apply a process that includes  
19 features of the provisions of sub-  
20 section (m)(3)(C) for MIPS eligible  
21 professionals in a group practice with  
22 respect to assessing the performance  
23 of such group with respect to the per-  
24 formance categories described in

1 clauses (ii) through (iv) of such para-  
2 graph.

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

10 “(E) USE OF REGISTRIES.—Under the  
11 MIPS, the Secretary shall encourage the use of  
12 qualified clinical data registries pursuant to  
13 subsection (m)(3)(E) in carrying out this sub-  
14 section.

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

19 “(i) adjust the application of such  
20 provision to ensure the provision is con-  
21 sistent with the provisions of this sub-  
22 section; and

23 “(ii) not apply such provision to the  
24 extent that the provision is duplicative with  
25 a provision of this subsection.

1 “(G) ACCOUNTING FOR RISK FACTORS.—

2 “(i) RISK FACTORS.—Taking into ac-  
3 count the relevant studies conducted and  
4 recommendations made in reports under  
5 section 2(d) of the Improving Medicare  
6 Post-Acute Care Transformation Act of  
7 2014, and, as appropriate, other informa-  
8 tion, including information collected before  
9 completion of such studies and rec-  
10 ommendations, the Secretary, on an ongo-  
11 ing basis, shall, as the Secretary deter-  
12 mines appropriate and based on an individ-  
13 ual’s health status and other risk factors—

14 “(I) assess appropriate adjust-  
15 ments to quality measures, resource  
16 use measures, and other measures  
17 used under the MIPS; and

18 “(II) assess and implement ap-  
19 propriate adjustments to payment ad-  
20 justments, composite performance  
21 scores, scores for performance cat-  
22 egories, or scores for measures or ac-  
23 tivities under the MIPS.

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

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

“(i) Quality.

“(ii) Resource use.

“(iii) Clinical practice improvement activities.

“(iv) Meaningful use of certified EHR technology.

“(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

“(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of 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, such as same day appointments for urgent needs and after hours access to clinician advice.

“(II) The subcategory of population management, such as monitoring health conditions of individuals

1 to provide timely health care interven-  
2 tions or participation in a qualified  
3 clinical data registry.

4 “(III) The subcategory of care  
5 coordination, such as timely commu-  
6 nication of test results, timely ex-  
7 change of clinical information to pa-  
8 tients and other providers, and use of  
9 remote monitoring or telehealth.

10 “(IV) The subcategory of bene-  
11 ficiary engagement, such as the estab-  
12 lishment of care plans for individuals  
13 with complex care needs, beneficiary  
14 self-management assessment and  
15 training, and using shared decision-  
16 making mechanisms.

17 “(V) The subcategory of patient  
18 safety and practice assessment, such  
19 as through use of clinical or surgical  
20 checklists and practice assessments  
21 related to maintaining certification.

22 “(VI) The subcategory of partici-  
23 pation in an alternative payment  
24 model (as defined in section  
25 1833(z)(3)(C)).

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

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

15 “(C) ADDITIONAL PROVISIONS.—

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

22 “(ii) APPLICATION OF ADDITIONAL  
23 SYSTEM MEASURES.—The Secretary may  
24 use measures used for a payment system  
25 other than for physicians, such as meas-

ures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of items and services furnished by emergency physicians, radiologists, and anesthesiologists.

“(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

“(iv) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROFESSIONALS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

“(I) shall give consideration to the circumstances of professional types (or subcategories of those types

1 determined by practice characteris-  
2 tics) who typically furnish services  
3 that do not involve face-to-face inter-  
4 action with a patient; and

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

14 In carrying out the previous sentence, the  
15 Secretary shall consult with professionals  
16 of such professional types or subcategories.

17 “(v) CLINICAL PRACTICE IMPROVE-  
18 MENT ACTIVITIES.—

19 “(I) REQUEST FOR INFORMA-  
20 TION.—In initially applying subpara-  
21 graph (B)(iii), the Secretary shall use  
22 a request for information to solicit  
23 recommendations from stakeholders to  
24 identify activities described in such

subparagraph and specifying criteria  
for such activities.

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

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

“(bb) specifying criteria for  
such activities; and

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

“(III) CLINICAL PRACTICE IM-  
PROVEMENT ACTIVITIES DEFINED.—  
For purposes of this subsection, the  
term ‘clinical practice improvement  
activity’ means an activity that rel-  
evant eligible professional organiza-  
tions and other relevant stakeholders  
identify as improving clinical practice

1 or care delivery and that the Sec-  
 2 retary determines, when effectively ex-  
 3 ecuted, is likely to result in improved  
 4 outcomes.

5 “(D) ANNUAL LIST OF QUALITY MEASURES  
 6 AVAILABLE FOR MIPS ASSESSMENT.—

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

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

24 “(II) not later than November 1  
 25 of the year prior to the first day of

1 each subsequent performance period,  
2 update the final list of quality meas-  
3 ures from the previous year (and pub-  
4 lish such updated final list in the Fed-  
5 eral Register), by—

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

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

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

20 “(ii) CALL FOR QUALITY MEAS-  
21 URES.—

22 “(I) IN GENERAL.—Eligible pro-  
23 fessional organizations and other rel-  
24 evant stakeholders shall be requested  
25 to identify and submit quality meas-



ures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

“(II) ELIGIBLE PROFESSIONAL ORGANIZATION DEFINED.—In this subparagraph, the term ‘eligible professional organization’ means a professional organization as defined by nationally recognized specialty boards of certification or equivalent certification boards.

“(iii) REQUIREMENTS.—In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

“(I) provide that, to the extent practicable, all quality domains (as

1 defined in subsection (s)(1)(B)) are  
2 addressed by such measures; and

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

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

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

22 “(I) measures endorsed by a con-  
23 sensus-based entity;

24 “(II) measures developed under  
25 subsection (s); and

1 “(III) measures submitted under  
2 clause (ii)(I).

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

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

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

subsection beginning before the first performance period under the MIPS—

“(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

“(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

“(viii) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

“(ix) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the selection of measures under this subparagraph.

“(3) PERFORMANCE STANDARDS.—

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

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

12                   “(i) Historical performance standards.

13                   “(ii) Improvement.

14                   “(iii) The opportunity for continued  
 15                   improvement.

16          “(4) PERFORMANCE PERIOD.—The Secretary  
 17          shall establish a performance period (or periods) for  
 18          a year (beginning with 2019). Such performance pe-  
 19          riod (or periods) shall begin and end prior to the be-  
 20          ginning of such year and be as close as possible to  
 21          such year. In this subsection, such performance pe-  
 22          riod (or periods) for a year shall be referred to as  
 23          the performance period for the year.

24          “(5) COMPOSITE PERFORMANCE SCORE.—

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

22           “(B) INCENTIVE TO REPORT; ENCOUR-  
23          AGING USE OF CERTIFIED EHR TECHNOLOGY  
24          FOR REPORTING QUALITY MEASURES.—

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

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

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

24 “(II) with respect to a perform-  
25 ance period, with respect to a year,

1 for which a MIPS eligible professional  
 2 reports such measures through the  
 3 use of such EHR technology, treat  
 4 such professional as satisfying the  
 5 clinical quality measures reporting re-  
 6 quirement described in subsection  
 7 (o)(2)(A)(iii) for such year.

8 “(C) CLINICAL PRACTICE IMPROVEMENT  
 9 ACTIVITIES PERFORMANCE SCORE.—

10 “(i) RULE FOR CERTIFICATION.—A  
 11 MIPS eligible professional who is in a  
 12 practice that is certified as a patient-cen-  
 13 tered medical home or comparable spe-  
 14 cialty practice, as determined by the Sec-  
 15 retary, with respect to a performance pe-  
 16 riod shall be given the highest potential  
 17 score for the performance category de-  
 18 scribed in paragraph (2)(A)(iii) for such  
 19 period.

20 “(ii) APM PARTICIPATION.—Partici-  
 21 pation by a MIPS eligible professional in  
 22 an alternative payment model (as defined  
 23 in section 1833(z)(3)(C)) with respect to a  
 24 performance period shall earn such eligible  
 25 professional a minimum score of one-half



of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

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

“(D) ACHIEVEMENT AND IMPROVEMENT.—

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

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

1 account the improvement of the pro-  
 2 fessional; and

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

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

18 “(E) WEIGHTS FOR THE PERFORMANCE  
 19 CATEGORIES.—

20 “(i) IN GENERAL.—Under the meth-  
 21 odology developed under subparagraph (A),  
 22 subject to subparagraph (F)(i) and clause  
 23 (ii), the composite performance score shall  
 24 be determined as follows:

25 “(I) QUALITY.—

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

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

25                  “(II) RESOURCE USE.—

1                   “(aa) IN GENERAL.—Sub-  
2                   ject to item (bb), thirty percent  
3                   of such score shall be based on  
4                   performance with respect to the  
5                   category described in clause (ii)  
6                   of paragraph (2)(A).

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

21                  “(III) CLINICAL PRACTICE IM-  
22                  PROVEMENT ACTIVITIES.—Fifteen  
23                  percent of such score shall be based  
24                  on performance with respect to the

1 category described in clause (iii) of  
2 paragraph (2)(A).

3 “(IV) MEANINGFUL USE OF CER-  
4 TIFIED EHR TECHNOLOGY.—Twenty-  
5 five percent of such score shall be  
6 based on performance with respect to  
7 the category described in clause (iv) of  
8 paragraph (2)(A).

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

1 of the increase under this clause for such  
 2 year equals the total number of percentage  
 3 points reduced under the preceding sen-  
 4 tence for such year.

5 “(F) CERTAIN FLEXIBILITY FOR  
 6 WEIGHTING PERFORMANCE CATEGORIES, MEAS-  
 7 URES, AND ACTIVITIES.—Under the method-  
 8 ology under subparagraph (A), if there are not  
 9 sufficient measures and activities (described in  
 10 paragraph (2)(B)) applicable and available to  
 11 each type of eligible professional involved, the  
 12 Secretary shall assign different scoring weights  
 13 (including a weight of 0)—

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

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

“(G) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

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

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

“(i) IN GENERAL.—In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A) with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A)—

1           “(I) the assessment of perform-  
 2           ance provided under such methodology  
 3           with respect to such performance cat-  
 4           egories that is to be applied to each  
 5           such professional in such group for  
 6           such performance period shall be with  
 7           respect to the combined performance  
 8           of all such professionals in such group  
 9           for such period; and

10           “(II) with respect to the com-  
 11           posite performance score provided  
 12           under this paragraph for such per-  
 13           formance period for each such MIPS  
 14           eligible professional in such virtual  
 15           group, the components of the com-  
 16           posite performance score that assess  
 17           performance with respect to such per-  
 18           formance categories shall be based on  
 19           the assessment of the combined per-  
 20           formance under subclause (I) for such  
 21           performance categories and perform-  
 22           ance period.

23           “(ii) ELECTION OF PRACTICES TO BE  
 24           A VIRTUAL GROUP.—The Secretary shall,  
 25           in accordance with the requirements under



1 clause (iii), establish and have in place a  
2 process to allow an individual MIPS eligi-  
3 ble professional or a group practice con-  
4 sisting of not more than 10 MIPS eligible  
5 professionals to elect, with respect to a  
6 performance period for a year to be a vir-  
7 tual group under this subparagraph with  
8 at least one other such individual MIPS el-  
9 igible professional or group practice. Such  
10 a virtual group may be based on appro-  
11 priate classifications of providers, such as  
12 by geographic areas or by provider special-  
13 ties defined by nationally recognized spe-  
14 cialty boards of certification or equivalent  
15 certification boards.

16 “(iii) REQUIREMENTS.—The require-  
17 ments for the process under clause (ii)  
18 shall—

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

1                   “(II) provide that an individual  
 2                   MIPS eligible professional and a  
 3                   group practice described in clause (ii)  
 4                   may elect to be in no more than one  
 5                   virtual group for a performance period  
 6                   and that, in the case of such a group  
 7                   practice that elects to be in such vir-  
 8                   tual group for such performance pe-  
 9                   riod, such election applies to all MIPS  
 10                  eligible professionals in such group  
 11                  practice;

12                  “(III) provide that a virtual  
 13                  group be a combination of tax identi-  
 14                  fication numbers;

15                  “(IV) provide for formal written  
 16                  agreements among MIPS eligible pro-  
 17                  fessionals electing to be a virtual  
 18                  group under this subparagraph; and

19                  “(V) include such other require-  
 20                  ments as the Secretary determines ap-  
 21                  propriate.

22                  “(6) MIPS PAYMENTS.—

23                  “(A) MIPS ADJUSTMENT FACTOR.—Tak-  
 24                  ing into account paragraph (1)(G), the Sec-  
 25                  retary shall specify a MIPS adjustment factor

1 for each MIPS eligible professional for a year.  
2 Such MIPS adjustment factor for a MIPS eligi-  
3 ble professional for a year shall be in the form  
4 of a percent and shall be determined—

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

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

15 “(I) MIPS eligible professionals  
16 with composite performance scores for  
17 such year at or above such perform-  
18 ance threshold for such year receive  
19 zero or positive payment adjustment  
20 factors for such year in accordance  
21 with clause (iii), with such profes-  
22 sionals having higher composite per-  
23 formance scores receiving higher ad-  
24 justment factors; and

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

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

22 “(iv) in a manner such that—

23 “(I) subject to subclause (II),  
 24 MIPS eligible professionals with com-  
 25 posite performance scores described in

1 clause (ii)(II) for such year receive a  
 2 negative payment adjustment factor  
 3 on a linear sliding scale such that an  
 4 adjustment factor of 0 percent is as-  
 5 signed for a score at the performance  
 6 threshold and an adjustment factor of  
 7 the negative of the applicable percent  
 8 specified in subparagraph (B) is as-  
 9 signed for a score of 0; and

10 “(II) MIPS eligible professionals  
 11 with composite performance scores  
 12 that are equal to or greater than 0,  
 13 but not greater than  $\frac{1}{4}$  of the per-  
 14 formance threshold specified under  
 15 subparagraph (D)(i) for such year, re-  
 16 ceive a negative payment adjustment  
 17 factor that is equal to the negative of  
 18 the applicable percent specified in  
 19 subparagraph (B) for such year.

20 “(B) APPLICABLE PERCENT DEFINED.—

21 For purposes of this paragraph, the term ‘ap-  
 22 plicable percent’ means—

23 “(i) for 2019, 4 percent;

24 “(ii) for 2020, 5 percent;

25 “(iii) for 2021, 7 percent; and

1 “(iv) for 2022 and subsequent years,  
2 9 percent.

3 “(C) ADDITIONAL MIPS ADJUSTMENT FAC-  
4 TORS FOR EXCEPTIONAL PERFORMANCE.—For  
5 2019 and each subsequent year through 2024,  
6 in the case of a MIPS eligible professional with  
7 a composite performance score for a year at or  
8 above the additional performance threshold  
9 under subparagraph (D)(ii) for such year, in  
10 addition to the MIPS adjustment factor under  
11 subparagraph (A) for the eligible professional  
12 for such year, subject to subparagraph (F)(iv),  
13 the Secretary shall specify an additional positive  
14 MIPS adjustment factor for such professional  
15 and year. Such additional MIPS adjustment  
16 factors shall be in the form of a percent and de-  
17 termined by the Secretary in a manner such  
18 that professionals having higher composite per-  
19 formance scores above the additional perform-  
20 ance threshold receive higher additional MIPS  
21 adjustment factors.

22 “(D) ESTABLISHMENT OF PERFORMANCE  
23 THRESHOLDS.—

24 “(i) PERFORMANCE THRESHOLD.—

25 For each year of the MIPS, the Secretary

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

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

1 for computing such additional performance  
2 threshold for such a year:

3 “(I) The threshold shall be the  
4 score that is equal to the 25th per-  
5 centile of the range of possible com-  
6 posite performance scores above the  
7 performance threshold determined  
8 under clause (i).

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

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



factors under subparagraph (C). Each  
such performance threshold shall—

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

“(II) take into account—

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

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

“(E) APPLICATION OF MIPS ADJUSTMENT  
FACTORS.—In the case of items and services  
furnished by a MIPS eligible professional dur-  
ing a year (beginning with 2019), the amount  
otherwise paid under this part with respect to  
such items and services and MIPS eligible pro-  
fessional for such year, shall be multiplied by—

“(i) 1, plus

“(ii) the sum of—

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

4 “(II) as applicable, the additional  
 5 MIPS adjustment factor determined  
 6 under subparagraph (C) divided by  
 7 100.

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

10 “(i) APPLICATION OF SCALING FAC-  
 11 TOR.—

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

1 “(II) SCALING FACTOR LIMIT.—

2 In no case may be the scaling factor  
3 applied under this clause exceed 3.0.

4 “(ii) BUDGET NEUTRALITY REQUIRE-  
5 MENT.—

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

12 “(II) AGGREGATE INCREASES.—  
13 The amount described in this sub-  
14 clause is the estimated increase in the  
15 aggregate allowed charges resulting  
16 from the application of positive MIPS  
17 adjustment factors under subpara-  
18 graph (A) (after application of the  
19 scaling factor described in clause (i))  
20 to MIPS eligible professionals whose  
21 composite performance score for a  
22 year is above the performance thresh-  
23 old under subparagraph (D)(i) for  
24 such year.

1                   “(III)       AGGREGATE       DE-  
2                   CREASES.—The amount described in  
3                   this subclause is the estimated de-  
4                   crease in the aggregate allowed  
5                   charges resulting from the application  
6                   of negative MIPS adjustment factors  
7                   under subparagraph (A) to MIPS eli-  
8                   gible professionals whose composite  
9                   performance score for a year is below  
10                  the performance threshold under sub-  
11                  paragraph (D)(i) for such year.

12               “(iii) EXCEPTIONS.—

13                   “(I) In the case that all MIPS el-  
14                   igible professionals receive composite  
15                   performance scores for a year that are  
16                   below the performance threshold  
17                   under subparagraph (D)(i) for such  
18                   year, the negative MIPS adjustment  
19                   factors under subparagraph (A) shall  
20                   apply with respect to such MIPS eligi-  
21                   ble professionals and the budget neu-  
22                   trality requirement of clause (ii) and  
23                   the additional adjustment factors  
24                   under clause (iv) shall not apply for  
25                   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.—

11           “(I) IN GENERAL.—Subject to  
12           subclause (II), in specifying the MIPS  
13           additional adjustment factors under  
14           subparagraph (C) for each applicable  
15           MIPS eligible professional for a year,  
16           the Secretary shall ensure that the es-  
17           timated aggregate increase in pay-  
18           ments under this part resulting from  
19           the application of such additional ad-  
20           justment factors for MIPS eligible  
21           professionals in a year shall be equal  
22           (as estimated by the Secretary) to  
23           \$500,000,000 for each year beginning  
24           with 2019 and ending with 2024.

1                   “(II) LIMITATION ON ADDI-  
2                   TIONAL INCENTIVE PAYMENT ADJUST-  
3                   MENTS.—The MIPS additional ad-  
4                   justment factor under subparagraph  
5                   (C) for a year for an applicable MIPS  
6                   eligible professional whose composite  
7                   performance score is above the addi-  
8                   tional performance threshold under  
9                   subparagraph (D)(ii) for such year  
10                  shall not exceed 10 percent. The ap-  
11                  plication of the previous sentence may  
12                  result in an aggregate amount of ad-  
13                  ditional incentive payments that are  
14                  less than the amount specified in sub-  
15                  clause (I).

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

1 mation in the confidential feedback under paragraph  
2 (12).

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

10 “(9) PUBLIC REPORTING.—

11 “(A) IN GENERAL.—The Secretary shall,  
12 in an easily understandable format, make avail-  
13 able on the Physician Compare Internet website  
14 of the Centers for Medicare & Medicaid Serv-  
15 ices the following:

16 “(i) Information regarding the per-  
17 formance of MIPS eligible professionals  
18 under the MIPS, which—

19 “(I) shall include the composite  
20 score for each such MIPS eligible pro-  
21 fessional and the performance of each  
22 such MIPS eligible professional with  
23 respect to each performance category;  
24 and

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

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

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

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



1           such subparagraph prior to such information  
2           being made public.

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

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

20          “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-  
21          TICES AND PRACTICES IN HEALTH PROFESSIONAL  
22          SHORTAGE AREAS.—

23                 “(A) IN GENERAL.—The Secretary shall  
24                 enter into contracts or agreements with appro-  
25                 priate entities (such as quality improvement or-

ganizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

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

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

“(B) FUNDING FOR TECHNICAL ASSISTANCE.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Ac-

count of \$20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

“(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

“(A) PERFORMANCE FEEDBACK.—

“(i) IN GENERAL.—Beginning July 1, 2017, the Secretary—

“(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

“(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

“(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which

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

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

1                   “(iv) DISCLOSURE EXEMPTION.—  
2                   Feedback made available under this sub-  
3                   paragraph shall be exempt from disclosure  
4                   under section 552 of title 5, United States  
5                   Code.

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

11                  “(B) ADDITIONAL INFORMATION.—

12                  “(i) IN GENERAL.—Beginning July 1,  
13                  2018, the Secretary shall make available to  
14                  MIPS eligible professionals information,  
15                  with respect to individuals who are pa-  
16                  tients of such MIPS eligible professionals,  
17                  about items and services for which pay-  
18                  ment is made under this title that are fur-  
19                  nished to such individuals by other sup-  
20                  pliers and providers of services, which may  
21                  include information described in clause (ii).  
22                  Such information may be made available  
23                  under the previous sentence to such MIPS  
24                  eligible professionals by mechanisms deter-  
25                  mined appropriate by the Secretary, which

1 may include use of a web-based portal.  
2 Such information may be made available in  
3 accordance with the same or similar terms  
4 as data are made available to accountable  
5 care organizations participating in the  
6 shared savings program under section  
7 1899.

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

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

1                   ices so furnished, and the dates such  
2                   items and services were so furnished.

3                   “(II) Historical data, such as  
4                   averages and other measures of the  
5                   distribution if appropriate, of the  
6                   total, and components of, allowed  
7                   charges (and other figures as deter-  
8                   mined appropriate by the Secretary).

9                   “(13) REVIEW.—

10                   “(A) TARGETED REVIEW.—The Secretary  
11                   shall establish a process under which a MIPS  
12                   eligible professional may seek an informal re-  
13                   view of the calculation of the MIPS adjustment  
14                   factor (or factors) applicable to such eligible  
15                   professional under this subsection for a year.  
16                   The results of a review conducted pursuant to  
17                   the previous sentence shall not be taken into ac-  
18                   count for purposes of paragraph (6) with re-  
19                   spect to a year (other than with respect to the  
20                   calculation of such eligible professional’s MIPS  
21                   adjustment factor for such year or additional  
22                   MIPS adjustment factor for such year) after  
23                   the factors determined in subparagraph (A) and  
24                   subparagraph (C) of such paragraph have been  
25                   determined for such year.

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

5                   “(i) The methodology used to deter-  
6                   mine the amount of the MIPS adjustment  
7                   factor under paragraph (6)(A) and the  
8                   amount of the additional MIPS adjustment  
9                   factor under paragraph (6)(C) and the de-  
10                  termination of such amounts.

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

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

21                  “(iv) The methodology developed  
22                  under paragraph (5) that is used to cal-  
23                  culate performance scores and the calcula-  
24                  tion of such scores, including the weighting



1 of measures and activities under such  
2 methodology.”.

3 (2) GAO REPORTS.—

4 (A) EVALUATION OF ELIGIBLE PROFES-  
5 SIONAL MIPS.—Not later than October 1, 2021,  
6 the Comptroller General of the United States  
7 shall submit to Congress a report evaluating the  
8 eligible professional Merit-based Incentive Pay-  
9 ment System under subsection (q) of section  
10 1848 of the Social Security Act (42 U.S.C.  
11 1395w–4), as added by paragraph (1). Such re-  
12 port shall—

13 (i) examine the distribution of the  
14 composite performance scores and MIPS  
15 adjustment factors (and additional MIPS  
16 adjustment factors) for MIPS eligible pro-  
17 fessionals (as defined in subsection  
18 (q)(1)(c) of such section) under such pro-  
19 gram, and patterns relating to such scores  
20 and adjustment factors, including based on  
21 type of provider, practice size, geographic  
22 location, and patient mix;

23 (ii) provide recommendations for im-  
24 proving such program;

(iii) evaluate the impact of technical assistance funding under section 1848(q)(11) of the Social Security Act, as added by paragraph (1), on the ability of professionals to improve within such program or successfully transition to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)), with priority for such evaluation given to practices located in rural areas, health professional shortage areas (as designated in section 332(a)(1)(a) of the Public Health Service Act), and medically underserved areas; and

(iv) provide recommendations for optimizing the use of such technical assistance funds.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—

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

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

11 (II) makes recommendations on  
12 how to reduce the administrative bur-  
13 den involved in applying such quality  
14 measures.

15 (ii) REQUIREMENTS.—The report  
16 under clause (i) shall—

17 (I) consider those measures ap-  
18 plicable to individuals entitled to, or  
19 enrolled for, benefits under such part  
20 A, or enrolled under such part B and  
21 individuals under the age of 65; and

22 (II) focus on those measures that  
23 comprise the most significant compo-  
24 nent of the quality performance cat-  
25 egory of the eligible professional

1 MIPS incentive program under sub-  
2 section (q) of section 1848 of the So-  
3 cial Security Act (42 U.S.C. 1395w-  
4 4), as added by paragraph (1).

5 (C) STUDY ON ROLE OF INDEPENDENT  
6 RISK MANAGERS.—Not later than January 1,  
7 2017, the Comptroller General of the United  
8 States shall submit to Congress a report exam-  
9 ining whether entities that pool financial risk  
10 for physician practices, such as independent  
11 risk managers, can play a role in supporting  
12 physician practices, particularly small physician  
13 practices, in assuming financial risk for the  
14 treatment of patients. Such report shall exam-  
15 ine barriers that small physician practices cur-  
16 rently face in assuming financial risk for treat-  
17 ing patients, the types of risk management enti-  
18 ties that could assist physician practices in par-  
19 ticipating in two-sided risk payment models,  
20 and how such entities could assist with risk  
21 management and with quality improvement ac-  
22 tivities. Such report shall also include an anal-  
23 ysis of any existing legal barriers to such ar-  
24 rangements.

1 (D) STUDY TO EXAMINE RURAL AND  
2 HEALTH PROFESSIONAL SHORTAGE AREA AL-  
3 TERNATIVE PAYMENT MODELS.—Not later than  
4 October 1, 2021, the Comptroller General of  
5 the United States shall submit to Congress a  
6 report that examines the transition of profes-  
7 sionals in rural areas, health professional short-  
8 age areas (as designated in section  
9 332(a)(1)(A) of the Public Health Service Act),  
10 or medically underserved areas to an alternative  
11 payment model (as defined in section  
12 1833(z)(3) of the Social Security Act, as added  
13 by subsection (e)). Such report shall make rec-  
14 ommendations for removing administrative bar-  
15 riers to practices, including small practices con-  
16 sisting of 15 or fewer professionals, in rural  
17 areas, health professional shortage areas, and  
18 medically underserved areas to participation in  
19 such models.

20 (3) FUNDING FOR IMPLEMENTATION.—For  
21 purposes of implementing the provisions of and the  
22 amendments made by this section, the Secretary of  
23 Health and Human Services shall provide for the  
24 transfer of \$80,000,000 from the Supplementary  
25 Medical Insurance Trust Fund established under

1 section 1841 of the Social Security Act (42 U.S.C.  
 2 1395t) to the Centers for Medicare & Medicaid Pro-  
 3 gram Management Account for each of the fiscal  
 4 years 2015 through 2019. Amounts transferred  
 5 under this paragraph shall be available until ex-  
 6 pended.

7 (d) IMPROVING QUALITY REPORTING FOR COM-  
 8 POSITE SCORES.—

9 (1) CHANGES FOR GROUP REPORTING OP-  
 10 TION.—

11 (A) IN GENERAL.—Section  
 12 1848(m)(3)(C)(ii) of the Social Security Act  
 13 (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended  
 14 by inserting “and, for 2016 and subsequent  
 15 years, may provide” after “shall provide”.

16 (B) CLARIFICATION OF QUALIFIED CLIN-  
 17 ICAL DATA REGISTRY REPORTING TO GROUP  
 18 PRACTICES.—Section 1848(m)(3)(D) of the So-  
 19 cial Security Act (42 U.S.C. 1395w–  
 20 4(m)(3)(D)) is amended by inserting “and, for  
 21 2016 and subsequent years, subparagraph (A)  
 22 or (C)” after “subparagraph (A)”.

23 (2) CHANGES FOR MULTIPLE REPORTING PERI-  
 24 ODS AND ALTERNATIVE CRITERIA FOR SATISFAC-  
 25 TORY REPORTING.—Section 1848(m)(5)(F) of the

1 Social Security Act (42 U.S.C. 1395w–4(m)(5)(F))  
 2 is amended—

3 (A) by striking “and subsequent years”  
 4 and inserting “through reporting periods occur-  
 5 ring in 2015”; and

6 (B) by inserting “and, for reporting peri-  
 7 ods occurring in 2016 and subsequent years,  
 8 the Secretary may establish” after “shall estab-  
 9 lish”.

10 (3) PHYSICIAN FEEDBACK PROGRAM REPORTS  
 11 SUCCEEDED BY REPORTS UNDER MIPS.—Section  
 12 1848(n) of the Social Security Act (42 U.S.C.  
 13 1395w–4(n)) is amended by adding at the end the  
 14 following new paragraph:

15 “(11) REPORTS ENDING WITH 2017.—Reports  
 16 under the Program shall not be provided after De-  
 17 cember 31, 2017. See subsection (q)(12) for reports  
 18 under the eligible professionals Merit-based Incentive  
 19 Payment System.”.

20 (4) COORDINATION WITH SATISFYING MEANING-  
 21 FUL EHR USE CLINICAL QUALITY MEASURE REPORT-  
 22 ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of  
 23 the Social Security Act (42 U.S.C. 1395w–  
 24 4(o)(2)(A)(iii)) is amended by inserting “and sub-

1 section (q)(5)(B)(ii)(II)” after “Subject to subpara-  
 2 graph (B)(ii)”.

3 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

4 (1) INCREASING TRANSPARENCY OF PHYSICIAN-  
 5 FOCUSED PAYMENT MODELS.—Section 1868 of the  
 6 Social Security Act (42 U.S.C. 1395ee) is amended  
 7 by adding at the end the following new subsection:

8 “(c) PHYSICIAN-FOCUSED PAYMENT MODELS.—

9 “(1) TECHNICAL ADVISORY COMMITTEE.—

10 “(A) ESTABLISHMENT.—There is estab-  
 11 lished an ad hoc committee to be known as the  
 12 ‘Physician-Focused Payment Model Technical  
 13 Advisory Committee’ (referred to in this sub-  
 14 section as the ‘Committee’).

15 “(B) MEMBERSHIP.—

16 “(i) NUMBER AND APPOINTMENT.—  
 17 The Committee shall be composed of 11  
 18 members appointed by the Comptroller  
 19 General of the United States.

20 “(ii) QUALIFICATIONS.—The member-  
 21 ship of the Committee shall include indi-  
 22 viduals with national recognition for their  
 23 expertise in physician-focused payment  
 24 models and related delivery of care. No  
 25 more than 5 members of the Committee



1 shall be providers of services or suppliers,  
2 or representatives of providers of services  
3 or suppliers.

4 “(iii) PROHIBITION ON FEDERAL EM-  
5 PLOYMENT.—A member of the Committee  
6 shall not be an employee of the Federal  
7 Government.

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

18 “(v) DATE OF INITIAL APPOINT-  
19 MENTS.—The initial appointments of mem-  
20 bers of the Committee shall be made by  
21 not later than 180 days after the date of  
22 enactment of this subsection.

23 “(C) TERM; VACANCIES.—

24 “(i) TERM.—The terms of members of  
25 the Committee shall be for 3 years except

1           that the Comptroller General shall des-  
2           ignate staggered terms for the members  
3           first appointed.

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

14          “(D) DUTIES.—The Committee shall meet,  
15          as needed, to provide comments and rec-  
16          ommendations to the Secretary, as described in  
17          paragraph (2)(C), on physician-focused pay-  
18          ment models.

19          “(E) COMPENSATION OF MEMBERS.—

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

23                 “(ii) TRAVEL EXPENSES.—A member  
24                 of the Committee shall be allowed travel  
25                 expenses, including per diem in lieu of sub-

1           sistence, at rates authorized for an em-  
 2           ployee of an agency under subchapter I of  
 3           chapter 57 of title 5, United States Code,  
 4           while away from the home or regular place  
 5           of business of the member in the perform-  
 6           ance of the duties of the Committee.

7           “(F) OPERATIONAL AND TECHNICAL SUP-  
 8           PORT.—

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

17                   “(ii) FUNDING.—The Secretary shall  
 18           provide for the transfer, from the Federal  
 19           Supplementary Medical Insurance Trust  
 20           Fund under section 1841, such amounts as  
 21           are necessary to carry out this paragraph  
 22           (not to exceed \$5,000,000) for fiscal year  
 23           2015 and each subsequent fiscal year. Any  
 24           amounts transferred under the preceding

1 sentence for a fiscal year shall remain  
2 available until expended.

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

6 “(2) CRITERIA AND PROCESS FOR SUBMISSION  
7 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT  
8 MODELS.—

9 “(A) CRITERIA FOR ASSESSING PHYSICIAN-  
10 FOCUSED PAYMENT MODELS.—

11 “(i) RULEMAKING.—Not later than  
12 November 1, 2016, the Secretary shall,  
13 through notice and comment rulemaking,  
14 following a request for information, estab-  
15 lish criteria for physician-focused payment  
16 models, including models for specialist phy-  
17 sicians, that could be used by the Com-  
18 mittee for making comments and rec-  
19 ommendations pursuant to paragraph  
20 (1)(D).

21 “(ii) MEDPAC SUBMISSION OF COM-  
22 MENTS.—During the comment period for  
23 the proposed rule described in clause (i),  
24 the Medicare Payment Advisory Commis-  
25 sion may submit comments to the Sec-

1           retary on the proposed criteria under such  
2           clause.

3           “(iii) UPDATING.—The Secretary may  
4           update the criteria established under this  
5           subparagraph through rulemaking.

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

13          “(C) COMMITTEE REVIEW OF MODELS  
14          SUBMITTED.—The Committee shall, on a peri-  
15          odic basis, review models submitted under sub-  
16          paragraph (B), prepare comments and rec-  
17          ommendations regarding whether such models  
18          meet the criteria described in subparagraph  
19          (A), and submit such comments and rec-  
20          ommendations to the Secretary.

21          “(D) SECRETARY REVIEW AND RE-  
22          SPONSE.—The Secretary shall review the com-  
23          ments and recommendations submitted by the  
24          Committee under subparagraph (C) and post a  
25          detailed response to such comments and rec-

1           ommendations on the Internet website of the  
2           Centers for Medicare & Medicaid Services.

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

7           (2) INCENTIVE PAYMENTS FOR PARTICIPATION  
8           IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—  
9           Section 1833 of the Social Security Act (42 U.S.C.  
10          1395l) is amended by adding at the end the fol-  
11         lowing new subsection:

12         “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN  
13         ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

14                 “(1) PAYMENT INCENTIVE.—

15                         “(A) IN GENERAL.—In the case of covered  
16                         professional services furnished by an eligible  
17                         professional during a year that is in the period  
18                         beginning with 2019 and ending with 2024 and  
19                         for which the professional is a qualifying APM  
20                         participant with respect to such year, in addi-  
21                         tion to the amount of payment that would oth-  
22                         erwise be made for such covered professional  
23                         services under this part for such year, there  
24                         also shall be paid to such professional an  
25                         amount equal to 5 percent of the estimated ag-

gregate payment amounts for such covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases in which payment for covered professional services furnished by a qualifying APM participant in an alternative payment model—

“(i) is made to an eligible alternative payment entity rather than directly to the qualifying APM participant; or

“(ii) is made on a basis other than a fee-for-service basis (such as payment on a capitated basis).

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

“(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative

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

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

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

21 “(A) 2019 AND 2020.—With respect to  
 22 2019 and 2020, an eligible professional for  
 23 whom the Secretary determines that at least 25  
 24 percent of payments under this part for covered  
 25 professional services furnished by such profes-



1 sional during the most recent period for which  
 2 data are available (which may be less than a  
 3 year) were attributable to such services fur-  
 4 nished under this part through an eligible alter-  
 5 native payment entity.

6 “(B) 2021 AND 2022.—With respect to  
 7 2021 and 2022, an eligible professional de-  
 8 scribed in either of the following clauses:

9 “(i) MEDICARE PAYMENT THRESHOLD  
 10 OPTION.—An eligible professional for  
 11 whom the Secretary determines that at  
 12 least 50 percent of payments under this  
 13 part for covered professional services fur-  
 14 nished by such professional during the  
 15 most recent period for which data are  
 16 available (which may be less than a year)  
 17 were attributable to such services furnished  
 18 under this part through an eligible alter-  
 19 native payment entity.

20 “(ii) COMBINATION ALL-PAYER AND  
 21 MEDICARE PAYMENT THRESHOLD OP-  
 22 TION.—An eligible professional—

23 “(I) for whom the Secretary de-  
 24 termines, with respect to items and  
 25 services furnished by such professional

1 during the most recent period for  
2 which data are available (which may  
3 be less than a year), that at least 50  
4 percent of the sum of—

5 “(aa) payments described in  
6 clause (i); and

7 “(bb) all other payments, re-  
8 gardless of payer (other than  
9 payments made by the Secretary  
10 of Defense or the Secretary of  
11 Veterans Affairs and other than  
12 payments made under title XIX  
13 in a State in which no medical  
14 home or alternative payment  
15 model is available under the  
16 State program under that title),  
17 meet the requirement described in  
18 clause (iii)(I) with respect to pay-  
19 ments described in item (aa) and meet  
20 the requirement described in clause  
21 (iii)(II) with respect to payments de-  
22 scribed in item (bb);

23 “(II) for whom the Secretary de-  
24 termines at least 25 percent of pay-  
25 ments under this part for covered pro-

1           fessional services furnished by such  
 2           professional during the most recent  
 3           period for which data are available  
 4           (which may be less than a year) were  
 5           attributable to such services furnished  
 6           under this part through an eligible al-  
 7           ternative payment entity; and

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

13                   “(iii) REQUIREMENT.—For purposes  
 14          of clause (ii)(I)—

15                   “(I) the requirement described in  
 16          this subclause, with respect to pay-  
 17          ments described in item (aa) of such  
 18          clause, is that such payments are  
 19          made to an eligible alternative pay-  
 20          ment entity; and

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

1 “(aa) quality measures com-  
 2 parable to measures under the  
 3 performance category described  
 4 in section 1848(q)(2)(B)(i) apply;

5 “(bb) certified EHR tech-  
 6 nology is used; and

7 “(cc) the eligible profes-  
 8 sional participates in an entity  
 9 that—

10 “(AA) bears more than  
 11 nominal financial risk if ac-  
 12 tual aggregate expenditures  
 13 exceeds expected aggregate  
 14 expenditures; or

15 “(BB) with respect to  
 16 beneficiaries under title  
 17 XIX, is a medical home that  
 18 meets criteria comparable to  
 19 medical homes expanded  
 20 under section 1115A(c).

21 “(C) BEGINNING IN 2023.—With respect to  
 22 2023 and each subsequent year, an eligible pro-  
 23 fessional described in either of the following  
 24 clauses:

1                   “(i) MEDICARE PAYMENT THRESHOLD  
 2                   OPTION.—An eligible professional for  
 3                   whom the Secretary determines that at  
 4                   least 75 percent of payments under this  
 5                   part for covered professional services fur-  
 6                   nished by such professional during the  
 7                   most recent period for which data are  
 8                   available (which may be less than a year)  
 9                   were attributable to such services furnished  
 10                  under this part through an eligible alter-  
 11                  native payment entity.

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

15                       “(I) for whom the Secretary de-  
 16                       termines, with respect to items and  
 17                       services furnished by such professional  
 18                       during the most recent period for  
 19                       which data are available (which may  
 20                       be less than a year), that at least 75  
 21                       percent of the sum of—

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

24                               “(bb) all other payments, re-  
 25                               gardless of payer (other than

1 payments made by the Secretary  
2 of Defense or the Secretary of  
3 Veterans Affairs and other than  
4 payments made under title XIX  
5 in a State in which no medical  
6 home or alternative payment  
7 model is available under the  
8 State program under that title),  
9 meet the requirement described in  
10 clause (iii)(I) with respect to pay-  
11 ments described in item (aa) and meet  
12 the requirement described in clause  
13 (iii)(II) with respect to payments de-  
14 scribed in item (bb);

15 “(II) for whom the Secretary de-  
16 termines at least 25 percent of pay-  
17 ments under this part for covered pro-  
18 fessional services furnished by such  
19 professional during the most recent  
20 period for which data are available  
21 (which may be less than a year) were  
22 attributable to such services furnished  
23 under this part through an eligible al-  
24 ternative payment entity; 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 to an eligible alternative pay-  
13 ment entity; 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 arrangements in which—

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

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

1                   “(cc) the eligible profes-  
 2                   sional participates in an entity  
 3                   that—

4                   “(AA) bears more than  
 5                   nominal financial risk if ac-  
 6                   tual aggregate expenditures  
 7                   exceeds expected aggregate  
 8                   expenditures; or

9                   “(BB) with respect to  
 10                  beneficiaries under title  
 11                  XIX, is a medical home that  
 12                  meets criteria comparable to  
 13                  medical homes expanded  
 14                  under section 1115A(c).

15               “(D) USE OF PATIENT APPROACH.—The  
 16               Secretary may base the determination of wheth-  
 17               er an eligible professional is a qualifying APM  
 18               participant under this subsection and the deter-  
 19               mination of whether an eligible professional is a  
 20               partial qualifying APM participant under sec-  
 21               tion 1848(q)(1)(C)(iii) by using counts of pa-  
 22               tients in lieu of using payments and using the  
 23               same or similar percentage criteria (as specified  
 24               in this subsection and such section, respec-  
 25               tively), as the Secretary determines appropriate.



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

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

7           “(B) ELIGIBLE PROFESSIONAL.—The term  
8       ‘eligible professional’ has the meaning given  
9       that term in section 1848(k)(3)(B) and includes  
10      a group that includes such professionals.

11          “(C) ALTERNATIVE PAYMENT MODEL  
12      (APM).—The term ‘alternative payment model’  
13      means, other than for purposes of subpara-  
14      graphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of para-  
15      graph (2), any of the following:

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

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

21           “(iii) A demonstration under section  
22          1866C.

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

“(D) ELIGIBLE ALTERNATIVE PAYMENT ENTITY.—The term ‘eligible alternative payment entity’ means, with respect to a year, an entity that—

“(i) participates in an alternative payment model that—

“(I) requires participants in such model to use certified EHR technology (as defined in subsection (o)(4)); and

“(II) provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

“(ii)(I) bears financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount; or

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

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

1           “(A) The determination that an eligible  
2 professional is a qualifying APM participant  
3 under paragraph (2) and the determination  
4 that an entity is an eligible alternative payment  
5 entity under paragraph (3)(D).

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

10           (3) COORDINATION CONFORMING AMEND-  
11 MENTS.—Section 1833 of the Social Security Act  
12 (42 U.S.C. 1395l) is further amended—

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

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

1           ment for the service under subsection (z) and  
2           this subsection, respectively.”.

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

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

9                           “(xxi) Focusing primarily on physi-  
10                          cians’ services (as defined in section  
11                          1848(j)(3)) furnished by physicians who  
12                          are not primary care practitioners.

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

15                          “(xxiii) Focusing on risk-based models  
16                          for small physician practices which may in-  
17                          volve two-sided risk and prospective patient  
18                          assignment, and which examine risk-ad-  
19                          justed decreases in mortality rates, hos-  
20                          pital readmissions rates, and other relevant  
21                          and appropriate clinical measures.

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

1 (B) in subparagraph (C)(viii), by striking  
2 “other public sector or private sector payers”  
3 and inserting “other public sector payers, pri-  
4 vate sector payers, or Statewide payment mod-  
5 els”.

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

16 (6) INTEGRATING MEDICARE ADVANTAGE AL-  
17 TERNATIVE PAYMENT MODELS.—Not later than July  
18 1, 2016, the Secretary of Health and Human Serv-  
19 ices shall submit to Congress a study that examines  
20 the feasibility of integrating alternative payment  
21 models in the Medicare Advantage payment system.  
22 The study shall include the feasibility of including a  
23 value-based modifier and whether such modifier  
24 should be budget neutral.

1           (7) STUDY AND REPORT ON FRAUD RELATED  
2 TO ALTERNATIVE PAYMENT MODELS UNDER THE  
3 MEDICARE PROGRAM.—

4           (A) STUDY.—The Secretary of Health and  
5 Human Services, in consultation with the In-  
6 spector General of the Department of Health  
7 and Human Services, shall conduct a study  
8 that—

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

16                   (ii) identifies aspects of such alter-  
17 native payment models that are vulnerable  
18 to fraudulent activity; and

19                   (iii) examines the implications of waiv-  
20 ers to such laws granted in support of such  
21 alternative payment models, including  
22 under any potential expansion of such  
23 models.

24           (B) REPORT.—Not later than 2 years after  
25 the date of the enactment of this Act, the Sec-

1           retary shall submit to Congress a report con-  
 2           taining the results of the study conducted under  
 3           subparagraph (A). Such report shall include  
 4           recommendations for actions to be taken to re-  
 5           duce the vulnerability of such alternative pay-  
 6           ment models to fraudulent activity. Such report  
 7           also shall include, as appropriate, recommenda-  
 8           tions of the Inspector General for changes in  
 9           Federal fraud prevention laws to reduce such  
 10          vulnerability.

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

17          “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-  
 18          TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO  
 19          IMPROVE RESOURCE USE MEASUREMENT.—

20                 “(1) IN GENERAL.—In order to involve the phy-  
 21          sician, practitioner, and other stakeholder commu-  
 22          nities in enhancing the infrastructure for resource  
 23          use measurement, including for purposes of the  
 24          Merit-based Incentive Payment System under sub-  
 25          section (q) and alternative payment models under

1 section 1833(z), the Secretary shall undertake the  
 2 steps described in the succeeding provisions of this  
 3 subsection.

4 “(2) DEVELOPMENT OF CARE EPISODE AND PA-  
 5 TIENT CONDITION GROUPS AND CLASSIFICATION  
 6 CODES.—

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

12 “(B) PUBLIC AVAILABILITY OF EXISTING  
 13 EFFORTS TO DESIGN AN EPISODE GROUPE.—  
 14 Not later than 180 days after the date of the  
 15 enactment of this subsection, the Secretary  
 16 shall post on the Internet website of the Cen-  
 17 ters for Medicare & Medicaid Services a list of  
 18 the episode groups developed pursuant to sub-  
 19 section (n)(9)(A) and related descriptive infor-  
 20 mation.

21 “(C) STAKEHOLDER INPUT.—The Sec-  
 22 retary shall accept, through the date that is  
 23 120 days after the day the Secretary posts the  
 24 list pursuant to subparagraph (B), suggestions  
 25 from physician specialty societies, applicable



practitioner organizations, and other stakeholders for episode groups in addition to those 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  $\frac{1}{2}$  of expenditures under parts A and B (with such target increasing over time as appropriate); and

“(II) assign codes to such groups.

“(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under

1 clause (i), the Secretary shall take into ac-  
2 count—

3 “(I) the patient’s clinical prob-  
4 lems at the time items and services  
5 are furnished during an episode of  
6 care, such as the clinical conditions or  
7 diagnoses, whether or not inpatient  
8 hospitalization occurs, and the prin-  
9 cipal procedures or services furnished;  
10 and

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

13 “(iii) PATIENT CONDITION GROUPS.—  
14 In establishing the patient condition  
15 groups under clause (i), the Secretary shall  
16 take into account—

17 “(I) the patient’s clinical history  
18 at the time of a medical visit, such as  
19 the patient’s combination of chronic  
20 conditions, current health status, and  
21 recent significant history (such as  
22 hospitalization and major surgery dur-  
23 ing a previous period, such as 3  
24 months); and

1 “(II) other factors determined  
 2 appropriate by the Secretary, such as  
 3 eligibility status under this title (in-  
 4 cluding eligibility under section  
 5 226(a), 226(b), or 226A, and dual eli-  
 6 gibility under this title and title XIX).

7 “(E) DRAFT CARE EPISODE AND PATIENT  
 8 CONDITION GROUPS AND CLASSIFICATION  
 9 CODES.—Not later than 270 days after the end  
 10 of the comment period described in subpara-  
 11 graph (C), the Secretary shall post on the  
 12 Internet website of the Centers for Medicare &  
 13 Medicaid Services a draft list of the care epi-  
 14 sode and patient condition codes established  
 15 under subparagraph (D) (and the criteria and  
 16 characteristics assigned to such code).

17 “(F) SOLICITATION OF INPUT.—The Sec-  
 18 retary shall seek, through the date that is 120  
 19 days after the Secretary posts the list pursuant  
 20 to subparagraph (E), comments from physician  
 21 specialty societies, applicable practitioner orga-  
 22 nizations, and other stakeholders, including rep-  
 23 resentatives of individuals entitled to benefits  
 24 under part A or enrolled under this part, re-  
 25 garding the care episode and patient condition

groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

“(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 270 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

“(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection

(n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

“(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

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

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

1           such as a physician or applicable practitioner  
2           who—

3                   “(i) considers himself to have the  
4                   primary responsibility for the general and  
5                   ongoing care for the patient over extended  
6                   periods of time;

7                   “(ii) considers himself to be the lead  
8                   physician or practitioner and who furnishes  
9                   items and services and coordinates care  
10                  furnished by other physicians or practi-  
11                  tioners for the patient during an acute epi-  
12                  sode;

13                  “(iii) furnishes items and services to  
14                  the patient on a continuing basis during an  
15                  acute episode of care, but in a supportive  
16                  rather than a lead role;

17                  “(iv) furnishes items and services to  
18                  the patient on an occasional basis, usually  
19                  at the request of another physician or  
20                  practitioner; or

21                  “(v) furnishes items and services only  
22                  as ordered by another physician or practi-  
23                  tioner.

24                  “(C) DRAFT LIST OF PATIENT RELATION-  
25                  SHIP CATEGORIES AND CODES.—Not later than

1 one year after the date of the enactment of this  
2 subsection, the Secretary shall post on the  
3 Internet website of the Centers for Medicare &  
4 Medicaid Services a draft list of the patient re-  
5 lationship categories and codes developed under  
6 subparagraph (B).

7 “(D) STAKEHOLDER INPUT.—The Sec-  
8 retary shall seek, through the date that is 120  
9 days after the Secretary posts the list pursuant  
10 to subparagraph (C), comments from physician  
11 specialty societies, applicable practitioner orga-  
12 nizations, and other stakeholders, including rep-  
13 resentatives of individuals entitled to benefits  
14 under part A or enrolled under this part, re-  
15 garding the patient relationship categories and  
16 codes posted under subparagraph (C). In seek-  
17 ing such comments, the Secretary shall use one  
18 or more mechanisms (other than notice and  
19 comment rulemaking) that may include open  
20 door forums, town hall meetings, web-based fo-  
21 rums, or other appropriate mechanisms.

22 “(E) OPERATIONAL LIST OF PATIENT RE-  
23 LATIONSHIP CATEGORIES AND CODES.—Not  
24 later than 240 days after the end of the com-  
25 ment period described in subparagraph (D),

1 taking into account the comments received  
2 under such subparagraph, the Secretary shall  
3 post on the Internet website of the Centers for  
4 Medicare & Medicaid Services an operational  
5 list of patient relationship categories and codes.

6 “(F) SUBSEQUENT REVISIONS.—Not later  
7 than November 1 of each year (beginning with  
8 2018), the Secretary shall, through rulemaking,  
9 make revisions to the operational list of patient  
10 relationship categories and codes as the Sec-  
11 retary determines appropriate. Such revisions  
12 may be based on experience, new information  
13 developed pursuant to subsection (n)(9)(A), and  
14 input from the physician specialty societies, ap-  
15 plicable practitioner organizations, and other  
16 stakeholders, including representatives of indi-  
17 viduals entitled to benefits under part A or en-  
18 rolled under this part.

19 “(4) REPORTING OF INFORMATION FOR RE-  
20 SOURCE USE MEASUREMENT.—Claims submitted for  
21 items and services furnished by a physician or appli-  
22 cable practitioner on or after January 1, 2018, shall,  
23 as determined appropriate by the Secretary, in-  
24 clude—



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

3           “(B) the national provider identifier of the  
4           ordering physician or applicable practitioner (if  
5           different from the billing physician or applicable  
6           practitioner).

7           “(5) METHODOLOGY FOR RESOURCE USE ANAL-  
8           YSIS.—

9           “(A) IN GENERAL.—In order to evaluate  
10          the resources used to treat patients (with re-  
11          spect to care episode and patient condition  
12          groups), the Secretary shall, as the Secretary  
13          determines appropriate—

14               “(i) use the patient relationship codes  
15               reported on claims pursuant to paragraph  
16               (4) to attribute patients (in whole or in  
17               part) to one or more physicians and appli-  
18               cable practitioners;

19               “(ii) use the care episode and patient  
20               condition codes reported on claims pursu-  
21               ant to paragraph (4) as a basis to compare  
22               similar patients and care episodes and pa-  
23               tient condition groups; and

1 “(iii) conduct an analysis of resource  
2 use (with respect to care episodes and pa-  
3 tient condition groups of such patients).

4 “(B) ANALYSIS OF PATIENTS OF PHYSI-  
5 CIANS AND PRACTITIONERS.—In conducting the  
6 analysis described in subparagraph (A)(iii) with  
7 respect to patients attributed to physicians and  
8 applicable practitioners, the Secretary shall, as  
9 feasible—

10 “(i) use the claims data experience of  
11 such patients by patient condition codes  
12 during a common period, such as 12  
13 months; and

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

16 “(I) in the case of episodes with-  
17 out a hospitalization, during periods  
18 of time (such as the number of days)  
19 determined appropriate by the Sec-  
20 retary; and

21 “(II) in the case of episodes with  
22 a hospitalization, during periods of  
23 time (such as the number of days) be-  
24 fore, during, and after the hospitaliza-  
25 tion.

1                   “(C) MEASUREMENT OF RESOURCE USE.—

2                   In measuring such resource use, the Sec-  
3                   retary—

4                   “(i) shall use per patient total allowed  
5                   charges for all services under part A and  
6                   this part (and, if the Secretary determines  
7                   appropriate, part D) for the analysis of pa-  
8                   tient resource use, by care episode codes  
9                   and by patient condition codes; and

10                  “(ii) may, as determined appropriate,  
11                  use other measures of allowed charges  
12                  (such as subtotals for categories of items  
13                  and services) and measures of utilization of  
14                  items and services (such as frequency of  
15                  specific items and services and the ratio of  
16                  specific items and services among attrib-  
17                  uted patients or episodes).

18                  “(D) STAKEHOLDER INPUT.—The Sec-  
19                  retary shall seek comments from the physician  
20                  specialty societies, applicable practitioner orga-  
21                  nizations, and other stakeholders, including rep-  
22                  resentatives of individuals entitled to benefits  
23                  under part A or enrolled under this part, re-  
24                  garding the resource use methodology estab-  
25                  lished pursuant to this paragraph. In seeking

1           comments the Secretary shall use one or more  
2           mechanisms (other than notice and comment  
3           rulemaking) that may include open door fo-  
4           rums, town hall meetings, web-based forums, or  
5           other appropriate mechanisms.

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

15          “(7) LIMITATION.—There shall be no adminis-  
16          trative or judicial review under section 1869, section  
17          1878, or otherwise of—

18                 “(A) care episode and patient condition  
19                 groups and codes established under paragraph  
20                 (2);

21                 “(B) patient relationship categories and  
22                 codes established under paragraph (3); and

23                 “(C) measurement of, and analyses of re-  
24                 source use with respect to, care episode and pa-

1           tient condition codes and patient relationship  
2           codes pursuant to paragraph (5).

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

5           “(9) DEFINITIONS.—In this subsection:

6                 “(A) PHYSICIAN.—The term ‘physician’  
7                 has the meaning given such term in section  
8                 1861(r)(1).

9                 “(B) APPLICABLE PRACTITIONER.—The  
10                term ‘applicable practitioner’ means—

11                         “(i) a physician assistant, nurse prac-  
12                         titioner, and clinical nurse specialist (as  
13                         such terms are defined in section  
14                         1861(aa)(5)), and a certified registered  
15                         nurse anesthetist (as defined in section  
16                         1861(bb)(2)); and

17                         “(ii) beginning January 1, 2019, such  
18                         other eligible professionals (as defined in  
19                         subsection (k)(3)(B)) as specified by the  
20                         Secretary.

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

1 **SEC. 3. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**  
 2 **OPMENT.**

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

7 “(s) PRIORITIES AND FUNDING FOR MEASURE DE-  
 8 VELOPMENT.—

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

11 “(A) DRAFT MEASURE DEVELOPMENT  
 12 PLAN.—Not later than January 1, 2016, the  
 13 Secretary shall develop, and post on the Inter-  
 14 net website of the Centers for Medicare & Med-  
 15 icaid Services, a draft plan for the development  
 16 of quality measures for application under the  
 17 applicable provisions (as defined in paragraph  
 18 (5)). Under such plan the Secretary shall—

19 “(i) address how measures used by  
 20 private payers and integrated delivery sys-  
 21 tems could be incorporated under title  
 22 XVIII;

23 “(ii) describe how coordination, to the  
 24 extent possible, will occur across organiza-  
 25 tions developing such measures; and

1 “(iii) take into account how clinical  
 2 best practices and clinical practice guide-  
 3 lines should be used in the development of  
 4 quality measures.

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

8 “(i) Clinical care.

9 “(ii) Safety.

10 “(iii) Care coordination.

11 “(iv) Patient and caregiver experience.

12 “(v) Population health and preven-  
 13 tion.

14 “(C) CONSIDERATION.—In developing the  
 15 draft plan under this paragraph, the Secretary  
 16 shall consider—

17 “(i) gap analyses conducted by the en-  
 18 tity with a contract under section 1890(a)  
 19 or other contractors or entities;

20 “(ii) whether measures are applicable  
 21 across health care settings;

22 “(iii) clinical practice improvement ac-  
 23 tivities submitted under subsection  
 24 (q)(2)(C)(iv) for identifying possible areas  
 25 for future measure development and identi-

1           fying existing gaps with respect to such  
2           measures; and

3           “(iv) the quality domains applied  
4           under this subsection.

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

8           “(i) Outcome measures, including pa-  
9           tient reported outcome and functional sta-  
10          tus measures.

11          “(ii) Patient experience measures.

12          “(iii) Care coordination measures.

13          “(iv) Measures of appropriate use of  
14          services, including measures of over use.

15          “(E) STAKEHOLDER INPUT.—The Sec-  
16          retary shall accept through March 1, 2016,  
17          comments on the draft plan posted under para-  
18          graph (1)(A) from the public, including health  
19          care providers, payers, consumers, and other  
20          stakeholders.

21          “(F) FINAL MEASURE DEVELOPMENT  
22          PLAN.—Not later than May 1, 2016, taking  
23          into account the comments received under this  
24          subparagraph, the Secretary shall finalize the  
25          plan and post on the Internet website of the



Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

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

“(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

“(B) PRIORITIZATION.—

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

“(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

1                   “(I) whether such measures  
2                   would be electronically specified; and

3                   “(II) clinical practice guidelines  
4                   to the extent that such guidelines  
5                   exist.

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

7                   “(A) IN GENERAL.—Not later than May 1,  
8                   2017, and annually thereafter, the Secretary  
9                   shall post on the Internet website of the Cen-  
10                  ters for Medicare & Medicaid Services a report  
11                  on the progress made in developing quality  
12                  measures for application under the applicable  
13                  provisions.

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

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

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

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

1 “(II) the name of each measure  
2 developed;

3 “(III) the name of the developer  
4 and steward of each measure;

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

9 “(V) whether the measure would  
10 be electronically specified.

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

13 “(I) the information described in  
14 clause (ii), if available; and

15 “(II) a timeline for completion of  
16 the development of such measures.

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

23 “(v) Other information the Secretary  
24 determines to be appropriate.

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

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

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

10                  “(C) other areas related to quality measure  
11                  development determined appropriate by the Sec-  
12                  retary.

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

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

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

18           “(6) FUNDING.—For purposes of carrying out  
19           this subsection, the Secretary shall provide for the  
20           transfer, from the Federal Supplementary Medical  
21           Insurance Trust Fund under section 1841, of  
22           \$15,000,000 to the Centers for Medicare & Medicaid  
23           Services Program Management Account for each of  
24           fiscal years 2015 through 2019. Amounts trans-

1       ferred under this paragraph shall remain available  
2       through the end of fiscal year 2022.

3               “(7) ADMINISTRATION.—Chapter 35 of title 44,  
4       United States Code, shall not apply to the collection  
5       of information for the development of quality meas-  
6       ures.”.

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

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

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

14               “(A) IN GENERAL.—In order to encourage  
15      the management of care for individuals with  
16      chronic care needs the Secretary shall, subject  
17      to subparagraph (B), make payment (as the  
18      Secretary determines to be appropriate) under  
19      this section for chronic care management serv-  
20      ices furnished on or after January 1, 2015, by  
21      a physician (as defined in section 1861(r)(1)),  
22      physician assistant or nurse practitioner (as de-  
23      fined in section 1861(aa)(5)(A)), clinical nurse  
24      specialist (as defined in section

1 1861(aa)(5)(B)), or certified nurse midwife (as  
 2 defined in section 1861(gg)(2)).

3 “(B) POLICIES RELATING TO PAYMENT.—

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

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

10 “(ii) not make payment under sub-  
 11 paragraph (A) if such payment would be  
 12 duplicative of payment that is otherwise  
 13 made under this title for such services; and

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

20 (b) EDUCATION AND OUTREACH.—

21 (1) CAMPAIGN.—

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

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

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

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

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

19 (2) REPORT.—Not later than December 31,  
20 2017, the Secretary shall submit to Congress a re-  
21 port on the use of chronic care management services  
22 described in such section 1848(b)(8) by individuals  
23 living in rural areas and by racial and ethnic minor-  
24 ity populations. Such report shall—

1 (A) identify barriers to receiving chronic  
2 care management services; and

3 (B) make recommendations for increasing  
4 the appropriate use of chronic care manage-  
5 ment services.

6 **SEC. 5. EMPOWERING BENEFICIARY CHOICES THROUGH**  
7 **CONTINUED ACCESS TO INFORMATION ON**  
8 **PHYSICIANS' SERVICES.**

9 (a) IN GENERAL.—On an annual basis (beginning  
10 with 2015), the Secretary shall make publicly available,  
11 in an easily understandable format, information with re-  
12 spect to physicians and, as appropriate, other eligible pro-  
13 fessionals on items and services furnished to Medicare  
14 beneficiaries under title XVIII of the Social Security Act  
15 (42 U.S.C. 1395 et seq.).

16 (b) TYPE AND MANNER OF INFORMATION.—The in-  
17 formation made available under this section shall be simi-  
18 lar to the type of information in the Medicare Provider  
19 Utilization and Payment Data: Physician and Other Sup-  
20 plier Public Use File released by the Secretary with re-  
21 spect to 2012 and shall be made available in a manner  
22 similar to the manner in which the information in such  
23 File is made available.



1       (c) REQUIREMENTS.—The information made avail-  
2 able under this section shall include, at a minimum, the  
3 following:

4           (1) Information on the number of services fur-  
5 nished by the physician or other eligible professional  
6 under part B of title XVIII of the Social Security  
7 Act (42 U.S.C. 1395j et seq.), which may include in-  
8 formation on the most frequent services furnished or  
9 groupings of services.

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

12          (3) A unique identifier for the physician or  
13 other eligible professional that is available to the  
14 public, such as a national provider identifier.

15       (d) SEARCHABILITY.—The information made avail-  
16 able under this section shall be searchable by at least the  
17 following:

18           (1) The specialty or type of the physician or  
19 other eligible professional.

20           (2) Characteristics of the services furnished,  
21 such as volume or groupings of services.

22           (3) The location of the physician or other eligi-  
23 ble professional.

24       (e) INTEGRATION ON PHYSICIAN COMPARE.—Begin-  
25 ning with 2016, the Secretary shall integrate the informa-

1 tion made available under this section on Physician Com-  
 2 pare.

3 (f) DEFINITIONS.—In this section:

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

8 (2) PHYSICIAN COMPARE.—The term “Physi-  
 9 cian Compare” means the Physician Compare Inter-  
 10 net website of the Centers for Medicare & Medicaid  
 11 Services (or a successor website).

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

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

15 (1) ADDITIONAL ANALYSES.—

16 (A) IN GENERAL.—Subject to subpara-  
 17 graph (B), to the extent consistent with appli-  
 18 cable information, privacy, security, and disclo-  
 19 sure laws (including paragraph (3)), notwith-  
 20 standing paragraph (4)(B) of section 1874(e) of  
 21 the Social Security Act (42 U.S.C. 1395kk(e))  
 22 and the second sentence of paragraph (4)(D) of  
 23 such section, beginning July 1, 2016, a quali-  
 24 fied entity may use the combined data described  
 25 in paragraph (4)(B)(iii) of such section received

1 by such entity under such section, and informa-  
2 tion derived from the evaluation described in  
3 such paragraph (4)(D), to conduct additional  
4 non-public analyses (as determined appropriate  
5 by the Secretary) and provide or sell such anal-  
6 yses to authorized users for non-public use (in-  
7 cluding for the purposes of assisting providers  
8 of services and suppliers to develop and partici-  
9 pate in quality and patient care improvement  
10 activities, including developing new models of  
11 care).

12 (B) LIMITATIONS WITH RESPECT TO ANAL-  
13 YSES.—

14 (i) EMPLOYERS.—Any analyses pro-  
15 vided or sold under subparagraph (A) to  
16 an employer described in paragraph  
17 (9)(A)(iii) may only be used by such em-  
18 ployer for purposes of providing health in-  
19 surance to employees and retirees of the  
20 employer.

21 (ii) HEALTH INSURANCE ISSUERS.—A  
22 qualified entity may not provide or sell an  
23 analysis to a health insurance issuer de-  
24 scribed in paragraph (9)(A)(iv) unless the  
25 issuer is providing the qualified entity with

1 data under section 1874(e)(4)(B)(iii) of  
2 the Social Security Act (42 U.S.C.  
3 1395kk(e)(4)(B)(iii)).

4 (2) ACCESS TO CERTAIN DATA.—

5 (A) ACCESS.—To the extent consistent  
6 with applicable information, privacy, security,  
7 and disclosure laws (including paragraph (3)),  
8 notwithstanding paragraph (4)(B) of section  
9 1874(e) of the Social Security Act (42 U.S.C.  
10 1395kk(e)) and the second sentence of para-  
11 graph (4)(D) of such section, beginning July 1,  
12 2016, a qualified entity may—

13 (i) provide or sell the combined data  
14 described in paragraph (4)(B)(iii) of such  
15 section to authorized users described in  
16 clauses (i), (ii), and (v) of paragraph  
17 (9)(A) for non-public use, including for the  
18 purposes described in subparagraph (B);  
19 or

20 (ii) subject to subparagraph (C), pro-  
21 vide Medicare claims data to authorized  
22 users described in clauses (i), (ii), and (v),  
23 of paragraph (9)(A) for non-public use, in-  
24 cluding for the purposes described in sub-  
25 paragraph (B).

1 (B) PURPOSES DESCRIBED.—The purposes  
 2 described in this subparagraph are assisting  
 3 providers of services and suppliers in developing  
 4 and participating in quality and patient care  
 5 improvement activities, including developing  
 6 new models of care.

7 (C) MEDICARE CLAIMS DATA MUST BE  
 8 PROVIDED AT NO COST.—A qualified entity may  
 9 not charge a fee for providing the data under  
 10 subparagraph (A)(ii).

11 (3) PROTECTION OF INFORMATION.—

12 (A) IN GENERAL.—Except as provided in  
 13 subparagraph (B), an analysis or data that is  
 14 provided or sold under paragraph (1) or (2)  
 15 shall not contain information that individually  
 16 identifies a patient.

17 (B) INFORMATION ON PATIENTS OF THE  
 18 PROVIDER OF SERVICES OR SUPPLIER.—To the  
 19 extent consistent with applicable information,  
 20 privacy, security, and disclosure laws, an anal-  
 21 ysis or data that is provided or sold to a pro-  
 22 vider of services or supplier under paragraph  
 23 (1) or (2) may contain information that individ-  
 24 ually identifies a patient of such provider or  
 25 supplier, including with respect to items and

1 services furnished to the patient by other pro-  
2 viders of services or suppliers.

3 (C) PROHIBITION ON USING ANALYSES OR  
4 DATA FOR MARKETING PURPOSES.—An author-  
5 ized user shall not use an analysis or data pro-  
6 vided or sold under paragraph (1) or (2) for  
7 marketing purposes.

8 (4) DATA USE AGREEMENT.—A qualified entity  
9 and an authorized user described in clauses (i), (ii),  
10 and (v) of paragraph (9)(A) shall enter into an  
11 agreement regarding the use of any data that the  
12 qualified entity is providing or selling to the author-  
13 ized user under paragraph (2). Such agreement shall  
14 describe the requirements for privacy and security of  
15 the data and, as determined appropriate by the Sec-  
16 retary, any prohibitions on using such data to link  
17 to other individually identifiable sources of informa-  
18 tion. If the authorized user is not a covered entity  
19 under the rules promulgated pursuant to the Health  
20 Insurance Portability and Accountability Act of  
21 1996, the agreement shall identify the relevant regu-  
22 lations, as determined by the Secretary, that the  
23 user shall comply with as if it were acting in the ca-  
24 pacity of such a covered entity.

1           (5) NO REDISCLOSURE OF ANALYSES OR  
2 DATA.—

3           (A) IN GENERAL.—Except as provided in  
4 subparagraph (B), an authorized user that is  
5 provided or sold an analysis or data under  
6 paragraph (1) or (2) shall not redisclose or  
7 make public such analysis or data or any anal-  
8 ysis using such data.

9           (B) PERMITTED REDISCLOSURE.—A pro-  
10 vider of services or supplier that is provided or  
11 sold an analysis or data under paragraph (1) or  
12 (2) may, as determined by the Secretary, redis-  
13 close such analysis or data for the purposes of  
14 performance improvement and care coordination  
15 activities but shall not make public such anal-  
16 ysis or data or any analysis using such data.

17          (6) OPPORTUNITY FOR PROVIDERS OF SERV-  
18 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-  
19 fied entity providing or selling an analysis to an au-  
20 thorized user under paragraph (1), to the extent  
21 that such analysis would individually identify a pro-  
22 vider of services or supplier who is not being pro-  
23 vided or sold such analysis, such qualified entity  
24 shall provide such provider or supplier with the op-  
25 portunity to appeal and correct errors in the manner

described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

(A) IN GENERAL.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

(B) ASSESSMENT.—The assessment under subparagraph (A) shall be an amount up to \$100 for each individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title—

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom



1 the qualified entity provided data on to the  
2 authorized user under paragraph (2).

3 (C) DEPOSIT OF AMOUNTS COLLECTED.—

4 Any amounts collected pursuant to this para-  
5 graph shall be deposited in Federal Supple-  
6 mentary Medical Insurance Trust Fund under  
7 section 1841 of the Social Security Act (42  
8 U.S.C. 1395t).

9 (8) ANNUAL REPORTS.—Any qualified entity  
10 that provides or sells an analysis or data under  
11 paragraph (1) or (2) shall annually submit to the  
12 Secretary a report that includes—

13 (A) a summary of the analyses provided or  
14 sold, including the number of such analyses, the  
15 number of purchasers of such analyses, and the  
16 total amount of fees received for such analyses;

17 (B) a description of the topics and pur-  
18 poses of such analyses;

19 (C) information on the entities who re-  
20 ceived the data under paragraph (2), the uses  
21 of the data, and the total amount of fees re-  
22 ceived for providing, selling, or sharing the  
23 data; and

24 (D) other information determined appro-  
25 priate by the Secretary.

1           (9) DEFINITIONS.—In this subsection and sub-  
2       section (b):

3           (A) AUTHORIZED USER.—The term “au-  
4       thorized user” means the following:

5                   (i) A provider of services.

6                   (ii) A supplier.

7                   (iii) An employer (as defined in sec-  
8       tion 3(5) of the Employee Retirement In-  
9       surance Security Act of 1974).

10                  (iv) A health insurance issuer (as de-  
11       fined in section 2791 of the Public Health  
12       Service Act).

13                  (v) A medical society or hospital asso-  
14       ciation.

15                  (vi) Any entity not described in  
16       clauses (i) through (v) that is approved by  
17       the Secretary (other than an employer or  
18       health insurance issuer not described in  
19       clauses (iii) and (iv), respectively, as deter-  
20       mined by the Secretary).

21           (B) PROVIDER OF SERVICES.—The term  
22       “provider of services” has the meaning given  
23       such term in section 1861(u) of the Social Se-  
24       curity Act (42 U.S.C. 1395x(u)).

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

(D) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(E) SUPPLIER.—The term “supplier” has the meaning given such term in section 1861(d) of the Social Security Act (42 U.S.C. 1395x(d)).

(b) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—

(1) ACCESS.—

(A) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2016, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and manner determined to be appropriate) to such qualified clinical data registry for purposes of

1 linking such data with clinical outcomes data  
2 and performing risk-adjusted, scientifically valid  
3 analyses and research to support quality im-  
4 provement or patient safety, provided that any  
5 public reporting of such analyses or research  
6 that identifies a provider of services or supplier  
7 shall only be conducted with the opportunity of  
8 such provider or supplier to appeal and correct  
9 errors in the manner described in subsection  
10 (a)(6).

11 (B) DATA DESCRIBED.—The data de-  
12 scribed in this subparagraph is—

13 (i) claims data under the Medicare  
14 program under title XVIII of the Social  
15 Security Act; and

16 (ii) if the Secretary determines appro-  
17 priate, claims data under the Medicaid  
18 program under title XIX of such Act and  
19 the State Children’s Health Insurance Pro-  
20 gram under title XXI of such Act.

21 (2) FEE.—Data described in paragraph (1)(B)  
22 shall be provided to a qualified clinical data registry  
23 under paragraph (1) at a fee equal to the cost of  
24 providing such data. Any fee collected pursuant to  
25 the preceding sentence shall be deposited in the Cen-

1       ters for Medicare & Medicaid Services Program  
 2       Management Account.

3       (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED  
 4 ENTITIES.—Section 1874(e) of the Social Security Act  
 5 (42 U.S.C. 1395kk(e)) is amended—

6           (1) in the subsection heading, by striking  
 7       “MEDICARE”; and

8           (2) in paragraph (3)—

9               (A) by inserting after the first sentence the  
 10           following new sentence: “Beginning July 1,  
 11           2016, if the Secretary determines appropriate,  
 12           the data described in this paragraph may also  
 13           include standardized extracts (as determined by  
 14           the Secretary) of claims data under titles XIX  
 15           and XXI for assistance provided under such ti-  
 16           tles for one or more specified geographic areas  
 17           and time periods requested by a qualified enti-  
 18           ty.”; and

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

22       (d) REVISION OF PLACEMENT OF FEES.—Section  
 23 1874(e)(4)(A) of the Social Security Act (42 U.S.C.  
 24 1395kk(e)(4)(A)) is amended, in the second sentence—

1           (1) by inserting “, for periods prior to July 1,  
2           2016,” after “deposited”; and

3           (2) by inserting the following before the period  
4           at the end: “, and, beginning July 1, 2016, into the  
5           Centers for Medicare & Medicaid Services Program  
6           Management Account”.

7   **SEC. 7. REDUCING ADMINISTRATIVE BURDEN AND OTHER**  
8           **PROVISIONS.**

9           (a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-  
10          OUT TO PRIVATE CONTRACT.—

11           (1) INDEFINITE, CONTINUING AUTOMATIC EX-  
12          TENSION OF OPT OUT ELECTION.—

13           (A) IN GENERAL.—Section 1802(b)(3) of  
14          the Social Security Act (42 U.S.C. 1395a(b)(3))  
15          is amended—

16                   (i) in subparagraph (B)(ii), by strik-  
17                   ing “during the 2-year period beginning on  
18                   the date the affidavit is signed” and insert-  
19                   ing “during the applicable 2-year period  
20                   (as defined in subparagraph (D))”;

21                   (ii) in subparagraph (C), by striking  
22                   “during the 2-year period described in sub-  
23                   paragraph (B)(ii)” and inserting “during  
24                   the applicable 2-year period”; and

1 (iii) by adding at the end the fol-  
2 lowing new subparagraph:

3 “(D) APPLICABLE 2-YEAR PERIODS FOR  
4 EFFECTIVENESS OF AFFIDAVITS.—In this sub-  
5 section, the term ‘applicable 2-year period’  
6 means, with respect to an affidavit of a physi-  
7 cian or practitioner under subparagraph (B),  
8 the 2-year period beginning on the date the af-  
9 fidavit is signed and includes each subsequent  
10 2-year period unless the physician or practi-  
11 tioner involved provides notice to the Secretary  
12 (in a form and manner specified by the Sec-  
13 retary), not later than 30 days before the end  
14 of the previous 2-year period, that the physician  
15 or practitioner does not want to extend the ap-  
16 plication of the affidavit for such subsequent 2-  
17 year period.”.

18 (B) EFFECTIVE DATE.—The amendments  
19 made by subparagraph (A) shall apply to affi-  
20 davits entered into on or after the date that is  
21 60 days after the date of the enactment of this  
22 Act.

23 (2) PUBLIC AVAILABILITY OF INFORMATION ON  
24 OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section

1 1802(b) of the Social Security Act (42 U.S.C.  
2 1395a(b)) is amended—

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

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

9 (B) by redesignating paragraph (5) as  
10 paragraph (6); and

11 (C) by inserting after paragraph (4) the  
12 following new paragraph:

13 “(5) POSTING OF INFORMATION ON OPT-OUT  
14 PHYSICIANS AND PRACTITIONERS.—

15 “(A) IN GENERAL.—Beginning not later  
16 than February 1, 2016, the Secretary shall  
17 make publicly available through an appropriate  
18 publicly accessible website of the Department of  
19 Health and Human Services information on the  
20 number and characteristics of opt-out physi-  
21 cians and practitioners and shall update such  
22 information on such website not less often than  
23 annually.

24 “(B) INFORMATION TO BE INCLUDED.—  
25 The information to be made available under



1           subparagraph (A) shall include at least the fol-  
2           lowing with respect to opt-out physicians and  
3           practitioners:

4                   “(i) Their number.

5                   “(ii) Their physician or professional  
6                   specialty or other designation.

7                   “(iii) Their geographic distribution.

8                   “(iv) The timing of their becoming  
9                   opt-out physicians and practitioners, rel-  
10                  ative, to the extent feasible, to when they  
11                  first enrolled in the program under this  
12                  title and with respect to applicable 2-year  
13                  periods.

14                  “(v) The proportion of such physi-  
15                  cians and practitioners who billed for  
16                  emergency or urgent care services.”.

17       (b) GAINSHARING STUDY AND REPORT.—Not later  
18       than 6 months after the date of the enactment of this Act,  
19       the Secretary of Health and Human Services, in consulta-  
20       tion with the Inspector General of the Department of  
21       Health and Human Services, shall submit to Congress a  
22       report with legislative recommendations to amend existing  
23       fraud and abuse laws, through exceptions, safe harbors,  
24       or other narrowly targeted provisions, to permit  
25       gainsharing or similar arrangements between physicians

1 and hospitals that improve care while reducing waste and  
 2 increasing efficiency. The report shall—

3 (1) consider whether such provisions should  
 4 apply to ownership interests, compensation arrange-  
 5 ments, or other relationships;

6 (2) describe how the recommendations address  
 7 accountability, transparency, and quality, including  
 8 how best to limit inducements to stint on care, dis-  
 9 charge patients prematurely, or otherwise reduce or  
 10 limit medically necessary care; and

11 (3) consider whether a portion of any savings  
 12 generated by such arrangements should accrue to  
 13 the Medicare program under title XVIII of the So-  
 14 cial Security Act.

15 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC  
 16 HEALTH RECORD SYSTEMS.—

17 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-  
 18 SPREAD EHR INTEROPERABILITY.—

19 (A) OBJECTIVE.—As a consequence of a  
 20 significant Federal investment in the implemen-  
 21 tation of health information technology through  
 22 the Medicare and Medicaid EHR incentive pro-  
 23 grams, Congress declares it a national objective  
 24 to achieve widespread exchange of health infor-

1 mation through interoperable certified EHR  
2 technology nationwide by December 31, 2018.

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, 2016, 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, 2018, then the Sec-  
 8 retary shall submit to Congress a report, by not  
 9 later than December 31, 2019, 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 USE 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 action (such as to dis-  
5 able functionality) to limit or restrict the com-  
6 patibility or interoperability of the certified  
7 EHR technology”.

8 (B) FOR MEANINGFUL USE EHR HOS-  
9 PITALS.—Section 1886(n)(3)(A)(ii) of the So-  
10 cial Security Act (42 U.S.C.  
11 1395ww(n)(3)(A)(ii)) is amended by inserting  
12 before the period at the end the following: “,  
13 and the hospital demonstrates (through a proc-  
14 ess specified by the Secretary, such as the use  
15 of an attestation) that the hospital has not  
16 knowingly and willfully taken action (such as to  
17 disable functionality) to limit or restrict the  
18 compatibility or interoperability of the certified  
19 EHR technology”.

20 (C) EFFECTIVE DATE.—The amendments  
21 made by this subsection shall apply to meaning-  
22 ful EHR users as of the date that is one year  
23 after the date of the enactment of this Act.

1           (3) STUDY AND REPORT ON THE FEASIBILITY  
2           OF ESTABLISHING A MECHANISM TO COMPARE CER-  
3           TIFIED EHR TECHNOLOGY PRODUCTS.—

4           (A) STUDY.—The Secretary shall conduct  
5           a study to examine the feasibility of estab-  
6           lishing one or more mechanisms to assist pro-  
7           viders in comparing and selecting certified  
8           EHR technology products. Such mechanisms  
9           may include—

10           (i) a website with aggregated results  
11           of surveys of meaningful EHR users on  
12           the functionality of certified EHR tech-  
13           nology products to enable such users to di-  
14           rectly compare the functionality and other  
15           features of such products; and

16           (ii) information from vendors of cer-  
17           tified products that is made publicly avail-  
18           able in a standardized format.

19           The aggregated results of the surveys described  
20           in clause (i) may be made available through  
21           contracts with physicians, hospitals, or other or-  
22           ganizations that maintain such comparative in-  
23           formation described in such clause.

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

retary shall submit to Congress a report on mechanisms that would assist providers in comparing and selecting certified EHR technology products. The report shall include information on the benefits of, and resources needed to develop and maintain, such mechanisms.

(4) DEFINITIONS.—In this subsection:

(A) The term “certified EHR technology” has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w-4(o)(4)).

(B) The term “meaningful EHR user” has the meaning given such term under the Medicare EHR incentive programs.

(C) The term “Medicare and Medicaid EHR incentive programs” means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w-4(o), 1395w-23, 1395ww(n)); and

1 (ii) in the case of the Medicaid pro-  
 2 gram under title XIX of such Act, the in-  
 3 centive program under subsections  
 4 (a)(3)(F) and (t) of section 1903 of such  
 5 Act (42 U.S.C. 1396b).

6 (D) The term “Secretary” means the Sec-  
 7 retary of Health and Human Services.

8 (d) GAO STUDIES AND REPORTS ON THE USE OF  
 9 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-  
 10 MOTE PATIENT MONITORING SERVICES.—

11 (1) STUDY ON TELEHEALTH SERVICES.—The  
 12 Comptroller General of the United States shall con-  
 13 duct a study on the following:

14 (A) How the definition of telehealth across  
 15 various Federal programs and Federal efforts  
 16 can inform the use of telehealth in the Medicare  
 17 program under title XVIII of the Social Secu-  
 18 rity Act (42 U.S.C. 1395 et seq.).

19 (B) Issues that can facilitate or inhibit the  
 20 use of telehealth under the Medicare program  
 21 under such title, including oversight and profes-  
 22 sional licensure, changing technology, privacy  
 23 and security, infrastructure requirements, and  
 24 varying needs across urban and rural areas.



(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services monitors payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) STUDY ON REMOTE PATIENT MONITORING SERVICES.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study—

(i) of the dissemination of remote patient monitoring technology in the private health insurance market;

(ii) of the financial incentives in the private health insurance market relating to adoption of such technology;

(iii) of the barriers to adoption of such services under the Medicare program under title XVIII of the Social Security Act;

(iv) that evaluates the patients, conditions, and clinical circumstances that could most benefit from remote patient monitoring services; and

(v) that evaluates the challenges related to establishing appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) in order to accurately reflect the resources involved in furnishing such services.

(B) DEFINITIONS.—For purposes of this paragraph:

(i) REMOTE PATIENT MONITORING SERVICES.—The term “remote patient monitoring services” means services furnished through remote patient monitoring technology.

(ii) REMOTE PATIENT MONITORING TECHNOLOGY.—The term “remote patient monitoring technology” means a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or

1 information on activities of daily living and  
2 may include responses to assessment ques-  
3 tions collected on the devices wirelessly or  
4 through a telecommunications connection  
5 to a server that complies with the Federal  
6 regulations (concerning the privacy of indi-  
7 vidually identifiable health information)  
8 promulgated under section 264(c) of the  
9 Health Insurance Portability and Account-  
10 ability Act of 1996, as part of an estab-  
11 lished plan of care for that patient that in-  
12 cludes the review and interpretation of that  
13 data by a health care professional.

14 (3) REPORTS.—Not later than 24 months after  
15 the date of the enactment of this Act, the Comp-  
16 troller General shall submit to Congress—

17 (A) a report containing the results of the  
18 study conducted under paragraph (1); and

19 (B) a report containing the results of the  
20 study conducted under paragraph (2).

21 A report required under this paragraph shall be sub-  
22 mitted together with recommendations for such leg-  
23 islation and administrative action as the Comptroller  
24 General determines appropriate. The Comptroller  
25 General may submit one report containing the re-

1       sults described in subparagraphs (A) and (B) and  
 2       the recommendations described in the previous sen-  
 3       tence.

4       (e) RULE OF CONSTRUCTION REGARDING HEALTH  
 5 CARE PROVIDERS.—

6           (1) IN GENERAL.—Subject to paragraph (3),  
 7       the development, recognition, or implementation of  
 8       any guideline or other standard under any Federal  
 9       health care provision shall not be construed to estab-  
 10      lish the standard of care or duty of care owed by a  
 11      health care provider to a patient in any medical mal-  
 12      practice or medical product liability action or claim.

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

15           (A) FEDERAL HEALTH CARE PROVISION.—

16       The term “Federal health care provision”  
 17       means any provision of the Patient Protection  
 18       and Affordable Care Act (Public Law 111–  
 19       148), title I or subtitle B of title II of the  
 20       Health Care and Education Reconciliation Act  
 21       of 2010 (Public Law 111–152), or title XVIII  
 22       or XIX of the Social Security Act (42 U.S.C.  
 23       1395 et seq., 42 U.S.C. 1396 et seq.).

24           (B) HEALTH CARE PROVIDER.—The term  
 25       “health care provider” means any individual,

group practice, corporation of health care professionals, or hospital—

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

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

(C) MEDICAL MALPRACTICE OR MEDICAL PRODUCT LIABILITY ACTION OR CLAIM.—The term “medical malpractice or medical product liability action or claim” means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider’s prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321) or section 351 of the Public Health Service Act (42 U.S.C. 262)).

(D) STATE.—The term “State” includes the District of Columbia, Puerto Rico, and any

1           other commonwealth, possession, or territory of  
2           the United States.

3           (3) NO PREEMPTION.—Nothing in paragraph  
4           (1) or any provision of the Patient Protection and  
5           Affordable Care Act (Public Law 111–148), title I  
6           or subtitle B of title II of the Health Care and Edu-  
7           cation Reconciliation Act of 2010 (Public Law 111–  
8           152), or title XVIII or XIX of the Social Security  
9           Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et  
10          seq.) shall be construed to preempt any State or  
11          common law governing medical professional or med-  
12          ical product liability actions or claims.

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