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.

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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "SGR Repeal and Medicare Provider Payment Modernization Act of 2015".

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

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

(a) STABILIZING FEE UPDATES.—

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

(A) in subsection (d)—

(i) in paragraph (1)(A)—

(I) by inserting ''and ending with 2025'' after ''beginning with 2001''; and

(II) by inserting ''or a subsequent paragraph'' after ''paragraph (4)''; and

(ii) in paragraph (4)—

(I) in the heading, by inserting ''AND ENDING WITH 2014'' after ''YEARS BEGINNING WITH 2001''; and

(II) in subparagraph (A), by inserting ''and ending with 2014'' after ''a year beginning with 2001''; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting ''through 2014'' after ''of each succeeding year''; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''and ending with 2014'' after ''beginning with 2000''.

(2) UPDATE OF RATES FOR 2015 AND SUBSEQUENT YEARS.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in paragraph (1)(A), by adding at the end the following: ''There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) (referred to in this subsection as the 'qualifying APM conversion factor') and the other for other items and services (referred to in this subsection as the 'nonqualifying 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.

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

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

''(20) UPDATE FOR 2026 AND SUBSEQUENT YEARS.—For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 1.0 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.5 percent.''.

(3) MEDPAC REPORTS.—

(A) INITIAL REPORT.—Not later than July 1, 2017, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment is made under section 1848 of the

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

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

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

(B) FINAL REPORT.—Not later than July 1, 2021, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship described in subparagraph (A), including the results determined from applying the methodology included in the report submitted under such subparagraph.

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

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

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

(i) in clause (i), by striking ''2015 or any subsequent payment year'' and inserting ''each of 2015 through 2018'';

(ii) in clause (ii)(III), by striking ''each subsequent year'' and inserting ''2018''; and

(iii) in clause (iii)—

(I) in the heading, by striking ''AND SUBSEQUENT YEARS'';

(II) by striking ''and each subsequent year''; and

(III) by striking '', but in no case shall the applicable percent be less than 95 percent''.

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

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

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

(II) by inserting ", or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year'' after ''under such subsection for a year''; and

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

''(D) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—With respect to 2019 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.''.

(2) QUALITY REPORTING.—

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

(i) in clause (i), by striking ''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-

lic Law 111–148 as paragraph (8); and

(II) 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 processes under 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.''.

(3) VALUE-BASED PAYMENTS.—

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

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, with respect to specific physicians and groups of physicians the Secretary de-

termines appropriate, and for services furnished on or after January 1, 2017, with respect to all physicians and groups of physicians. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2019.''.

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

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

''(C) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).''; and

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

(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 eligible 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 DEFINED.—

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

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

cialist (as such terms are defined in section 1861(aa)(5)), a certified registered nurse anesthetist (as defined in section 1861(bb)(2)), and a group that includes such professionals; and

''(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I), such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary, and a group that includes such professionals.

''(ii) EXCLUSIONS.—For purposes of clause (i), the term 'MIPS eligible professional' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

''(I) is a qualifying APM participant (as defined in section 1833(z)(2));

"(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are available and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

"(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

"(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term 'partial qualifying APM participant' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a quali-

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

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

"(II) with respect to 2021 and 2022—

"(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

"(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

"(III) with respect to 2023 and subsequent years—

"(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

''(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

''(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

''(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

''(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

''(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such profes-

sional under this part for such performance period.

''(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

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

"(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

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

"(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional

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

"(D) APPLICATION TO GROUP PRACTICES.—

"(i) IN GENERAL.—Under the MIPS:

"(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

"(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in

clauses (ii) through (iv) of such paragraph.

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

''(E) USE OF REGISTRIES.—Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

''(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

''(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

''(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

"(G) ACCOUNTING FOR RISK FACTORS.—

"(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 2(d) of the Improving Medicare Post-Acute Care Transformation Act of 2014, and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other risk factors—

"(I) assess appropriate adjustments to quality measures, resource use measures, and other measures used under the MIPS; and

"(II) assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

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

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

"(i) Quality.

"(ii) Resource use.

"(iii) Clinical practice improvement activities.

"(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

to provide timely health care interventions or participation in a qualified clinical data registry.

''(III) The subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

''(IV) The subcategory of beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

''(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

''(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

''(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

''(C) ADDITIONAL PROVISIONS.—

''(i) EMPHASIZING OUTCOME MEASURES UNDER THE QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

''(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system 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

determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

"(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

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

"(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

"(I) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such

subparagraph and specifying criteria for such activities.

''(II) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—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 IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice

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

''(D) ANNUAL LIST OF QUALITY MEASURES AVAILABLE FOR MIPS ASSESSMENT.—

''(i) IN GENERAL.—Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

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

''(II) not later than November 1 of the year prior to the first day of

each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

"(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

"(bb) adding to such list, as appropriate, new quality measures; and

"(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

"(ii) CALL FOR QUALITY MEASURES.—

"(I) IN GENERAL.—Eligible professional organizations and other relevant stakeholders shall be requested 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

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

''(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

''(iv) PEER REVIEW.—Before including a new measure in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

''(v) MEASURES FOR INCLUSION.—The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

''(I) measures endorsed by a consensus-based entity;

''(II) measures developed under subsection (s); and

"(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

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

"(vii) EXCEPTION FOR EXISTING QUALITY MEASURES.—Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period or 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.—

''(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

''(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

''(i) Historical performance standards.

''(ii) Improvement.

''(iii) The opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with 2019). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

''(5) COMPOSITE PERFORMANCE SCORE.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the 'composite performance score' for such professional for such performance period.

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

"(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

"(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

"(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

"(II) with respect to a performance period, with respect to a year,

for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

''(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

''(i) RULE FOR CERTIFICATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

''(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible 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

account the improvement of the professional; and

"(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

"(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Subject to clause (i), under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with respect to a measure, activity, or category described in paragraph (2).

"(E) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

"(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clause (ii), the composite performance score shall be determined as follows:

"(I) QUALITY.—

"(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

"(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

"(II) RESOURCE USE.—

"(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

"(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

"(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the

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

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

''(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points

of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

''(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

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

''(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible 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)—

''(I) the assessment of performance provided under such methodology with respect to such performance categories that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

''(II) with respect to the composite performance score provided under this paragraph for such performance period for each such MIPS eligible professional in such virtual group, the components of the composite performance score that assess performance with respect to such performance categories shall be based on the assessment of the combined performance under subclause (I) for such performance categories and performance period.

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

clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice. Such a virtual group may be based on appropriate classifications of providers, such as by geographic areas or by provider specialties defined by nationally recognized specialty boards of certification or equivalent certification boards.

''(iii) REQUIREMENTS.—The requirements for the process under clause (ii) shall—

''(I) provide that an election under such clause, with respect to a performance period, shall be made before the beginning of such performance period and may not be changed during such performance period;

''(II) provide that an individual MIPS eligible professional and a group practice described in clause (ii) may elect to be in no more than one virtual group for a performance period and that, in the case of such a group practice that elects to be in such virtual group for such performance period, such election applies to all MIPS eligible professionals in such group practice;

''(III) provide that a virtual group be a combination of tax identification numbers;

''(IV) provide for formal written agreements among MIPS eligible professionals electing to be a virtual group under this subparagraph; and

''(V) include such other requirements as the Secretary determines appropriate.

''(6) MIPS PAYMENTS.—

''(A) MIPS ADJUSTMENT FACTOR.—Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor

for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

"(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

"(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

"(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

"(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

"(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

"(iv) in a manner such that—

"(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in

clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

''(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

''(B) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

''(i) for 2019, 4 percent;

''(ii) for 2020, 5 percent;

''(iii) for 2021, 7 percent; and

"(iv) for 2022 and subsequent years, 9 percent.

"(C) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—For 2019 and each subsequent year through 2024, in the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to subparagraph (F)(iv), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be in the form of a percent and determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

"(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

"(i) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary

shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection of the mean or median under the previous sentence every 3 years.

''(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORMANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C). For each such year, the Secretary shall apply either of the following methods

for computing such additional performance threshold for such a year:

"(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold determined under clause (i).

"(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

"(iii) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of 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 respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

"(bb) other factors determined appropriate by the Secretary.

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

"(i) 1, plus

"(ii) the sum of—

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

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

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

''(i) APPLICATION OF SCALING FACTOR.—

''(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

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

"(ii) BUDGET NEUTRALITY REQUIREMENT.—

"(I) IN GENERAL.—Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

"(II) AGGREGATE INCREASES.—The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

"(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

"(iii) EXCEPTIONS.—

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

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

"(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—

"(I) IN GENERAL.—Subject to subclause (II), in specifying the MIPS additional adjustment factors under subparagraph (C) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated aggregate increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to $500,000,000 for each year beginning with 2019 and ending with 2024.

"(II) LIMITATION ON ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—The MIPS additional adjustment factor under subparagraph (C) for a year for an applicable MIPS eligible professional whose composite performance score is above the additional performance threshold under subparagraph (D)(ii) for such year shall not exceed 10 percent. The application of the previous sentence may result in an aggregate amount of additional incentive payments that are less than the amount specified in subclause (I).

"(7) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for items and services furnished by the professional for such year. The Secretary may include such infor-

mation in the confidential feedback under paragraph (12).

''(8) NO EFFECT IN SUBSEQUENT YEARS.—The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

''(9) PUBLIC REPORTING.—

''(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

''(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

''(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

"(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

"(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

"(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under

such subparagraph prior to such information being made public.

''(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

''(10) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

''(11) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate 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

may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

''(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

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

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

"(B) ADDITIONAL INFORMATION.—

"(i) IN GENERAL.—Beginning July 1, 2018, the Secretary shall make available to MIPS eligible professionals information, with respect to individuals who are patients of such MIPS eligible professionals, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which

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

''(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

''(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and serv-

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

"(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

"(13) REVIEW.—

"(A) TARGETED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor (or factors) applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

''(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C) and the determination of such amounts.

''(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

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

''(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting

of measures and activities under such methodology.''.

(2) GAO REPORTS.—

(A) EVALUATION OF ELIGIBLE PROFESSIONAL MIPS.—Not later than October 1, 2021, the Comptroller General of the United States shall submit to Congress a report evaluating the eligible professional Merit-based Incentive Payment System under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1). Such report shall—

(i) examine the distribution of the composite performance scores and MIPS adjustment factors (and additional MIPS adjustment factors) for MIPS eligible professionals (as defined in subsection (q)(1)(c) of such section) under such program, and patterns relating to such scores and adjustment factors, including based on type of provider, practice size, geographic location, and patient mix;

(ii) provide recommendations for improving 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—

(I) compares the similarities and differences in the use of quality measures under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, selected State Medicaid programs under title XIX of such Act, and private payer arrangements; and

(II) makes recommendations on how to reduce the administrative burden involved in applying such quality measures.

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

(I) consider those measures applicable to individuals entitled to, or enrolled for, benefits under such part A, or enrolled under such part B and individuals under the age of 65; and

(II) focus on those measures that comprise the most significant component of the quality performance category of the eligible professional

MIPS incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1).

(C) STUDY ON ROLE OF INDEPENDENT RISK MANAGERS.—Not later than January 1, 2017, the Comptroller General of the United States shall submit to Congress a report examining whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices, particularly small physician practices, in assuming financial risk for the treatment of patients. Such report shall examine barriers that small physician practices currently face in assuming financial risk for treating patients, the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could assist with risk management and with quality improvement activities. Such report shall also include an analysis of any existing legal barriers to such arrangements.

(D) STUDY TO EXAMINE RURAL AND HEALTH PROFESSIONAL SHORTAGE AREA ALTERNATIVE PAYMENT MODELS.—Not later than October 1, 2021, the Comptroller General of the United States shall submit to Congress a report that examines the transition of professionals in rural areas, health professional shortage areas (as designated in section 332(a)(1)(A) of the Public Health Service Act), or medically underserved areas to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)). Such report shall make recommendations for removing administrative barriers to practices, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas to participation in such models.

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

section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2015 through 2019. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

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

(B) CLARIFICATION OF QUALIFIED CLINICAL DATA REGISTRY REPORTING TO GROUP PRACTICES.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting ''and, for 2016 and subsequent years, subparagraph (A) or (C)'' after ''subparagraph (A)''.

(2) CHANGES FOR MULTIPLE REPORTING PERIODS AND ALTERNATIVE CRITERIA FOR SATISFACTORY REPORTING.—Section 1848(m)(5)(F) of the

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

(A) by striking ''and subsequent years'' and inserting ''through reporting periods occurring in 2015''; and

(B) by inserting ''and, for reporting periods occurring in 2016 and subsequent years, the Secretary may establish'' after ''shall establish''.

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

''(11) REPORTS ENDING WITH 2017.—Reports under the Program shall not be provided after December 31, 2017. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.''.

(4) COORDINATION WITH SATISFYING MEANINGFUL EHR USE CLINICAL QUALITY MEASURE REPORTING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(iii)) is amended by inserting ''and sub-

section (q)(5)(B)(ii)(II)'' after ''Subject to subparagraph (B)(ii)''.

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

''(c) PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(1) TECHNICAL ADVISORY COMMITTEE.—

''(A) ESTABLISHMENT.—There is established an ad hoc committee to be known as the 'Physician-Focused Payment Model Technical Advisory Committee' (referred to in this subsection as the 'Committee').

''(B) MEMBERSHIP.—

''(i) NUMBER AND APPOINTMENT.—The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

''(ii) QUALIFICATIONS.—The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee

shall be providers of services or suppliers, or representatives of providers of services or suppliers.

''(iii) PROHIBITION ON FEDERAL EMPLOYMENT.—A member of the Committee shall not be an employee of the Federal Government.

''(iv) ETHICS DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(v) DATE OF INITIAL APPOINTMENTS.—The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

''(C) TERM; VACANCIES.—

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

that the Comptroller General shall designate staggered terms for the members first appointed.

''(ii) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

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

''(E) COMPENSATION OF MEMBERS.—

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

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

sistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

''(F) OPERATIONAL AND TECHNICAL SUPPORT.—

''(i) IN GENERAL.—The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

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

sentence for a fiscal year shall remain available until expended.

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

''(2) CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(i) RULEMAKING.—Not later than November 1, 2016, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

''(ii) MEDPAC SUBMISSION OF COMMENTS.—During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Sec-

retary on the proposed criteria under such clause.

"(iii) UPDATING.—The Secretary may update the criteria established under this subparagraph through rulemaking.

"(B) STAKEHOLDER SUBMISSION OF PHYSICIAN-FOCUSED PAYMENT MODELS.—On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

"(C) COMMITTEE REVIEW OF MODELS SUBMITTED.—The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

"(D) SECRETARY REVIEW AND RESPONSE.—The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and rec-

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

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.''.

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

''(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

''(1) PAYMENT INCENTIVE.—

''(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2019 and ending with 2024 and for which the professional is a qualifying APM participant with respect to such year, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an 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

payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

''(D) COORDINATION.—The amount of the additional payment under this subsection or subsection (m) shall be determined without regard to any additional payment under subsection (m) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (x) shall be determined without regard to any additional payment under subsection (x) and this subsection, respectively. The amount of the additional payment under this subsection or subsection (y) shall be determined without regard to any additional payment under subsection (y) and this subsection, respectively.

''(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term 'qualifying APM participant' means the following:

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

sional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

''(B) 2021 AND 2022.—With respect to 2021 and 2022, an eligible professional described in either of the following clauses:

''(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

''(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional

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

"(aa) payments described in clause (i); and

"(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

"(II) for whom the Secretary determines at least 25 percent of payments under this part for covered pro-

fessional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

"(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

"(bb) certified EHR technology is used; and

"(cc) the eligible professional participates in an entity that—

"(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

"(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

"(C) BEGINNING IN 2023.—With respect to 2023 and each subsequent year, an eligible professional described in either of the following clauses:

"(i) MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity.

"(ii) COMBINATION ALL-PAYER AND MEDICARE PAYMENT THRESHOLD OPTION.—An eligible professional—

"(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

"(aa) payments described in clause (i); and

"(bb) all other payments, regardless of payer (other than

payments made by the Secretary of Defense or the Secretary of Veterans Affairs and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an eligible alternative payment entity; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made to an eligible alternative payment entity; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under arrangements in which—

''(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

''(bb) certified EHR technology is used; and

"(cc) the eligible professional participates in an entity that—

"(AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or

"(BB) with respect to beneficiaries under title XIX, is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c).

"(D) USE OF PATIENT APPROACH.—The Secretary may base the determination of whether an eligible professional is a qualifying APM participant under this subsection and the determination of whether an eligible professional is a partial qualifying APM participant under section 1848(q)(1)(C)(iii) by using counts of patients in lieu of using payments and using the same or similar percentage criteria (as specified in this subsection and such section, respectively), as the Secretary determines appropriate.

''(3) ADDITIONAL DEFINITIONS.—In this subsection:

''(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given that term in section 1848(k)(3)(A).

''(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given that term in section 1848(k)(3)(B) and includes a group that includes such professionals.

''(C) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means, other than for purposes of subparagraphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of paragraph (2), any of the following:

''(i) A model under section 1115A (other than a health care innovation award).

''(ii) The shared savings program under section 1899.

''(iii) A demonstration under section 1866C.

''(iv) A demonstration required by 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:

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

''(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.''.

(3) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended—

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

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

ment for the service under subsection (z) and this subsection, respectively.''.

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

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

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

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

''(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

''(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services.''; and

(B) in subparagraph (C)(viii), by striking ''other public sector or private sector payers'' and inserting ''other public sector payers, private sector payers, or Statewide payment models''.

(5) CONSTRUCTION REGARDING TELEHEALTH SERVICES.—Nothing in the provisions of, or amendments made by, this Act shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)).

(6) INTEGRATING MEDICARE ADVANTAGE ALTERNATIVE PAYMENT MODELS.—Not later than July 1, 2016, the Secretary of Health and Human Services shall submit to Congress a study that examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system. The study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

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

(A) STUDY.—The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

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

(ii) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(iii) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

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

retary shall submit to Congress a report containing the results of the study conducted under subparagraph (A). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

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

''(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

''(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under

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

''(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

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

''(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 180 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

''(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 120 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions 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 ½ 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

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

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

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

"(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

"(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

"(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 270 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

"(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding 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),

such as a physician or applicable practitioner who—

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

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

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

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

"(v) furnishes items and services only as ordered by another physician or practitioner.

"(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than

one year after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 120 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, web-based forums, or other appropriate mechanisms.

''(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 240 days after the end of the comment period described in subparagraph (D),

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 patient relationship categories and codes.

"(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2018), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines 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.

"(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, shall, as determined appropriate by the Secretary, include—

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

"(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

"(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

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

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

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

"(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients).

"(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

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

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

"(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

"(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

"(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

"(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

"(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

"(D) STAKEHOLDER INPUT.—The Secretary shall seek comments 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, regarding the resource use methodology established pursuant to this paragraph. In seeking

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

''(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

''(7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) care episode and patient condition groups and codes established under paragraph (2);

''(B) patient relationship categories and codes established under paragraph (3); and

''(C) measurement of, and analyses of resource use with respect to, care episode and pa-

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

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

''(9) DEFINITIONS.—In this subsection:

''(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

''(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

''(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

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

''(10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.''.

SEC. 3. PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (f) of section 2, is further amended by inserting at the end the following new subsection:

''(s) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

''(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

''(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2016, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

''(i) address how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;

''(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

"(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

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

"(i) Clinical care.

"(ii) Safety.

"(iii) Care coordination.

"(iv) Patient and caregiver experience.

"(v) Population health and prevention.

"(C) CONSIDERATION.—In developing the draft plan under this paragraph, the Secretary shall consider—

"(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;

"(ii) whether measures are applicable across health care settings;

"(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identi-

fying existing gaps with respect to such measures; and

''(iv) the quality domains applied under this subsection.

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

''(i) Outcome measures, including patient reported outcome and functional status measures.

''(ii) Patient experience measures.

''(iii) Care coordination measures.

''(iv) Measures of appropriate use of services, including measures of over use.

''(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2016, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

''(F) FINAL MEASURE DEVELOPMENT PLAN.—Not later than May 1, 2016, taking into account the comments received under this subparagraph, the Secretary shall finalize the 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—

''(I) whether such measures would be electronically specified; and

''(II) clinical practice guidelines to the extent that such guidelines exist.

''(3) ANNUAL REPORT BY THE SECRETARY.—

''(A) IN GENERAL.—Not later than May 1, 2017, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

''(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

''(i) A description of the Secretary's efforts to implement this paragraph.

''(ii) With respect to the measures developed during the previous year—

''(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

''(II) the name of each measure developed;

''(III) the name of the developer and steward of each measure;

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

''(V) whether the measure would be electronically specified.

''(iii) With respect to measures in development at the time of the report—

''(I) the information described in clause (ii), if available; and

''(II) a timeline for completion of the development of such measures.

''(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

''(v) Other information the Secretary determines to be appropriate.

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

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

''(B) prioritizing quality measure development to address such gaps; and

''(C) other areas related to quality measure development determined appropriate by the Secretary.

''(5) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term 'applicable provisions' means the following provisions:

''(A) Subsection (q)(2)(B)(i).

''(B) Section 1833(z)(2)(C).

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

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

''(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information for the development of quality measures.''.

SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.

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

''(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

''(A) IN GENERAL.—In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), make payment (as the Secretary determines to be appropriate) under this section for chronic care management services furnished on or after January 1, 2015, by a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section

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

''(B) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

''(i) make payment to only one applicable provider for such services furnished to an individual during a period;

''(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services; and

''(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.''.

(b) EDUCATION AND OUTREACH.—

(1) CAMPAIGN.—

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

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

(B) REQUIREMENTS.—Such campaign shall—

(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

(2) REPORT.—Not later than December 31, 2017, the Secretary shall submit to Congress a report on the use of chronic care management services described in such section 1848(b)(8) by individuals living in rural areas and by racial and ethnic minority populations. Such report shall—

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

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

SEC. 5. EMPOWERING BENEFICIARY CHOICES THROUGH CONTINUED ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.

(a) IN GENERAL.—On an annual basis (beginning with 2015), the Secretary shall make publicly available, in an easily understandable format, information with respect to physicians and, as appropriate, other eligible professionals on items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) TYPE AND MANNER OF INFORMATION.—The information made available under this section shall be similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File released by the Secretary with respect to 2012 and shall be made available in a manner similar to the manner in which the information in such File is made available.

(c) REQUIREMENTS.—The information made available under this section shall include, at a minimum, the following:

(1) Information on the number of services furnished by the physician or other eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

(2) Information on submitted charges and payments for services under such part.

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

(d) SEARCHABILITY.—The information made available under this section shall be searchable by at least the following:

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

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

(3) The location of the physician or other eligible professional.

(e) INTEGRATION ON PHYSICIAN COMPARE.—Beginning with 2016, the Secretary shall integrate the informa-

tion made available under this section on Physician Compare.

(f) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SECRETARY.—The terms ''eligible professional'', ''physician'', and ''Secretary'' have the meaning given such terms in section 10331(i) of Public Law 111–148.

(2) PHYSICIAN COMPARE.—The term ''Physician Compare'' means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

SEC. 6. EXPANDING AVAILABILITY OF MEDICARE DATA.

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

(1) ADDITIONAL ANALYSES.—

(A) IN GENERAL.—Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2016, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received

by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) LIMITATIONS WITH RESPECT TO ANALYSES.—

(i) EMPLOYERS.—Any analyses provided or sold under subparagraph (A) to an employer described in paragraph (9)(A)(iii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(ii) HEALTH INSURANCE ISSUERS.—A qualified entity may not provide or sell an analysis to a health insurance issuer described in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with

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

(2) ACCESS TO CERTAIN DATA.—

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

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

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B).

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

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

(3) PROTECTION OF INFORMATION.—

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

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individually identifies a patient of such provider or supplier, including with respect to items and

services furnished to the patient by other providers of services or suppliers.

(C) PROHIBITION ON USING ANALYSES OR DATA FOR MARKETING PURPOSES.—An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

(4) DATA USE AGREEMENT.—A qualified entity and an authorized user described in clauses (i), (ii), and (v) of paragraph (9)(A) shall enter into an agreement regarding the use of any data that the qualified entity is providing or selling to the authorized user under paragraph (2). Such agreement shall describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the user shall comply with as if it were acting in the capacity of such a covered entity.

(5) NO REDISCLOSURE OF ANALYSES OR DATA.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) PERMITTED REDISCLOSURE.—A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, redisclose such analysis or data for the purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(6) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner

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

(7) ASSESSMENT FOR A BREACH.—

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

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

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

(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

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

(C) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

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

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

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(9) DEFINITIONS.—In this subsection and subsection (b):

(A) AUTHORIZED USER.—The term ''authorized user'' means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (iii) and (iv), respectively, as determined by the Secretary).

(B) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given such term in section 1861(u) of the Social Security 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

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

(B) DATA DESCRIBED.—The data described in this subparagraph is—

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

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act and the State Children's Health Insurance Program under title XXI of such Act.

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

ters for Medicare & Medicaid Services Program Management Account.

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

(1) in the subsection heading, by striking ''MEDICARE''; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: ''Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.''; and

(B) in the last sentence, by inserting ''or under titles XIX or XXI'' before the period at the end.

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

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

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

SEC. 7. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.

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

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

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

(i) in subparagraph (B)(ii), by striking "during the 2-year period beginning on the date the affidavit is signed" and inserting "during the applicable 2-year period (as defined in subparagraph (D))";

(ii) in subparagraph (C), by striking "during the 2-year period described in subparagraph (B)(ii)" and inserting "during the applicable 2-year period"; and

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

''(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.''.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act.

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

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

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

''(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).'';

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

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

''(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

''(A) IN GENERAL.—Beginning not later than February 1, 2016, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

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

subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

''(i) Their number.

''(ii) Their physician or professional specialty or other designation.

''(iii) Their geographic distribution.

''(iv) The timing of their becoming opt-out physicians and practitioners, relative, to the extent feasible, to when they first enrolled in the program under this title and with respect to applicable 2-year periods.

''(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.''.

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

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

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships;

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program under title XVIII of the Social Security Act.

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

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health infor-

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

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term ''widespread interoperability'' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

(ii) INTEROPERABILITY.—The term ''interoperability'' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2016, and in consultation with stakeholders, the Secretary shall establish metrics to be used to determine if and to the

extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2018, then the Secretary shall submit to Congress a report, by not later than December 31, 2019, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL USE EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before the period at the end the following: ‘‘, and the

professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(B) FOR MEANINGFUL USE EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: '', and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is one year after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A MECHANISM TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products. Such mechanisms may include—

(i) a website with aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products; and

(ii) information from vendors of certified products that is made publicly available in a standardized format.

The aggregated results of the surveys described in clause (i) may be made available through contracts with physicians, hospitals, or other organizations that maintain such comparative information described in such clause.

(B) REPORT.—Not later than 1 year after 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

(ii) in the case of the Medicaid program under title XIX of such Act, the incentive program under subsections (a)(3)(F) and (t) of section 1903 of such Act (42 U.S.C. 1396b).

(D) The term ''Secretary'' means the Secretary of Health and Human Services.

(d) GAO STUDIES AND REPORTS ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS AND ON REMOTE PATIENT MONITORING SERVICES.—

(1) STUDY ON TELEHEALTH SERVICES.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and Federal efforts can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and 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

information on activities of daily living and may include responses to assessment questions collected on the devices wirelessly or through a telecommunications connection to a server that complies with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as part of an established plan of care for that patient that includes the review and interpretation of that data by a health care professional.

(3) REPORTS.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress—

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

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

A report required under this paragraph shall be submitted together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate. The Comptroller General may submit one report containing the re-

sults described in subparagraphs (A) and (B) and the recommendations described in the previous sentence.

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

(1) IN GENERAL.—Subject to paragraph (3), the development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim.

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

(A) FEDERAL HEALTH CARE PROVISION.—The term ''Federal health care provision'' means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et seq.).

(B) HEALTH CARE PROVIDER.—The term ''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

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

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

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