

115TH CONGRESS  
1ST SESSION

# H. R. 4206

To amend title XVIII of the Social Security Act to modernize the physician self-referral prohibitions to promote care coordination in the merit-based incentive payment system and to facilitate physician practice participation in alternative payment models under the Medicare program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 1, 2017

Mr. BUCSHON (for himself, Mr. RUIZ, Mr. MARCHANT, and Mr. KIND) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to modernize the physician self-referral prohibitions to promote care coordination in the merit-based incentive payment system and to facilitate physician practice participation in alternative payment models under the Medicare program, and for other purposes.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Medicare Care Coordi-  
3 nation Improvement Act of 2017”.

4 **SEC. 2. MODERNIZATION OF LIMITATIONS ON PHYSICIAN**  
5 **SELF-REFERRAL.**

6 (a) **WAIVERS TO PROMOTE CARE COORDINATION BY**  
7 **FACILITATING PARTICIPATION IN ALTERNATIVE PAY-**  
8 **MENT MODELS.—**

9 (1) **IN GENERAL.—**Section 1833 of the Social  
10 Security Act (42 U.S.C. 1395l) is amended—

11 (A) in subsection (z), as added by section  
12 101(e)(2) of the Medicare Access and CHIP  
13 Reauthorization Act of 2015 (Public Law 114–  
14 10), by adding at the end the following new  
15 paragraph:

16 “(5) **WAIVER AUTHORITY.—**

17 “(A) **IN GENERAL.—**The provisions of sub-  
18 section (f) of section 1899 shall apply with re-  
19 spect to covered APM entities to the same ex-  
20 tent and in the same manner as such provisions  
21 apply with respect to accountable care organiza-  
22 tions under such section.

23 “(B) **COVERED APM ENTITIES.—**For pur-  
24 poses of subparagraph (A), the term ‘covered  
25 APM entity’ means, subject to subparagraph  
26 (C), each of the following:

1           “(i) An eligible alternative payment  
2           entity as defined in paragraph (3)(D).

3           “(ii) An entity participating in an al-  
4           ternative payment model as defined in  
5           paragraph (3)(C), including such participa-  
6           tion that qualifies as a clinical practice im-  
7           provement activity under section  
8           1848(q)(2)(B)(iii)(VI).

9           “(iii) An entity participating in a phy-  
10          sician-focused payment model for which  
11          comments and recommendations have,  
12          under subparagraph (C) of section  
13          1868(c)(2), been submitted indicating that  
14          such model meets the criteria described in  
15          subparagraph (A) of such section.

16          “(iv) An entity participating in any  
17          other model that the Secretary determines  
18          is a covered APM for purposes of subpara-  
19          graph (A), including such a determination  
20          made pursuant to physicians submitting a  
21          proposal to the Secretary for an alternative  
22          payment model.

23          “(v) An entity engaging in activities  
24          that the Secretary has determined con-  
25          stitute significant progress toward estab-

1           lishing a model referred to in any of  
2           clauses (i) through (iv).

3           “(C) CERTAIN REQUIREMENTS.—A model  
4           referred to in any of clauses (i) through (iv) of  
5           subparagraph (B) may not be considered a cov-  
6           ered APM entity for purposes of subparagraph  
7           (A) unless the model meets the requirements  
8           described in section 1877(b)(6)(B).”;

9           (B) by redesignating subsection (z), as  
10          added by section 514(a) of the Medicare Access  
11          and CHIP Reauthorization Act of 2015 (Public  
12          Law 114–10), as subsection (aa).

13          (2) CONFORMING AMENDMENT.—Section  
14          514(c)(1) of the Medicare Access and CHIP Reau-  
15          thorization Act of 2015 (Public Law 114–10) is  
16          amended by striking “subsection (z)” and inserting  
17          “subsection (aa)”.

18          (b) EXPANSION OF ADMINISTRATIVE AUTHORITY TO  
19          PROVIDE EXCEPTIONS TO PHYSICIAN OWNERSHIP AND  
20          COMPENSATION ARRANGEMENT PROHIBITIONS TO PRO-  
21          MOTE CARE COORDINATION.—

22          (1) PROMOTING CARE COORDINATION.—Section  
23          1877(b)(4) of the Social Security Act (U.S.C.  
24          1395nn(b)(4)) is amended by striking “risk of pro-  
25          gram or patient abuse” and inserting the following:

1 “significant risk of program or patient abuse, in-  
2 cluding those that would promote care coordination,  
3 quality improvement, or resource conservation by  
4 physician practices under part B”.

5 (2) CARE COORDINATION IN MIPS AND PARTICI-  
6 PATION IN APMS.—Section 1877(a) of the Social Se-  
7 curity Act (U.S.C. 1395nn(a)) is amended by adding  
8 at the end the following new paragraph:

9 “(3) LIMITATION.—The Secretary may not im-  
10 pose requirements under this section that could ad-  
11 versely affect—

12 “(A) physician care coordination in the  
13 merit-based incentive payment system under  
14 section 1848(q); or

15 “(B) physician participation in an alter-  
16 native payment model under 1833(z).”.

17 (c) EXCEPTION FACILITATING THE DEVELOPMENT  
18 AND OPERATION OF ALTERNATIVE PAYMENT MODELS.—  
19 Section 1877(b) of the Social Security Act (42 U.S.C.  
20 1395nn(b)) is amended by adding at the end the following  
21 new paragraph:

22 “(6) DEVELOPMENT AND OPERATION OF AL-  
23 TERNATIVE PAYMENT MODELS.—

24 “(A) IN GENERAL.—In the case of services  
25 furnished pursuant to an arrangement that

1 meets the requirements described in subpara-  
2 graph (B) entered into for the purpose of devel-  
3 oping or operating an alternative payment  
4 model, including—

5 “(i) advanced alternative payment  
6 models described in section 1833(z) (in-  
7 cluding physician-focused payment models  
8 referred to in section 1868(c));

9 “(ii) MIPS APMs (as defined by the  
10 Secretary); and

11 “(iii) any other alternative payment  
12 model that the Secretary may, by regula-  
13 tion, specify.

14 “(B) REQUIREMENTS.—The requirements  
15 described in this subparagraph with respect to  
16 an arrangement relating to an alternative pay-  
17 ment model are as follows:

18 “(i) The arrangement is in writing,  
19 identifies the services, items, or actions  
20 subject to the arrangement and is signed  
21 by the parties to the arrangement.

22 “(ii) Items and services furnished sub-  
23 ject to the arrangement are furnished at  
24 fair market value. In this clause, the term  
25 ‘fair market value’ has the meaning given

1           such term in subsection (h)(3), except that  
2           the Secretary may not take into account  
3           the volume or value of referrals in deter-  
4           mining such value for purposes of this  
5           clause.

6           “(iii) The arrangement includes a de-  
7           scription of the alternative payment model.

8           “(iv) Under the arrangement written  
9           reports are submitted to the Secretary on  
10          a semi-annual basis on the progress  
11          achieved in the development and operation  
12          of the alternative payment model

13          “(v) The arrangement meets such  
14          other requirements as the Secretary may  
15          impose by regulation as needed to protect  
16          against a significant risk of program pa-  
17          tient abuse”.

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