

114TH CONGRESS
1ST SESSION

H. R. 1470

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 HOUSE OF REPRESENTATIVES

MARCH 19, 2015

Mr. BURGESS (for himself, Mr. UPTON, Mr. LEVIN, Mr. RYAN of Wisconsin, Mr. PALLONE, Mr. PITTS, Mr. GENE GREEN of Texas, Mr. BRADY of Texas, Mr. McDERMOTT, and Mr. BOUSTANY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and the Judiciary, 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

A BILL

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

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

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

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

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

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

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

10 (a) **STABILIZING FEE UPDATES.**—

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

14 (A) in subsection (d)—

15 (i) in paragraph (1)(A)—

16 (I) by inserting “and ending with
 17 2025” after “beginning with 2001”;
 18 and

19 (II) by inserting “or a subse-
 20 quent paragraph” after “paragraph
 21 (4)”; and

1 (ii) in paragraph (4)—

2 (I) in the heading, by inserting
3 “AND ENDING WITH 2014” after
4 “YEARS BEGINNING WITH 2001”; and

5 (II) in subparagraph (A), by in-
6 serting “and ending with 2014” after
7 “a year beginning with 2001”; and

8 (B) in subsection (f)—

9 (i) in paragraph (1)(B), by inserting
10 “through 2014” after “of each succeeding
11 year”; and

12 (ii) in paragraph (2), in the matter
13 preceding subparagraph (A), by inserting
14 “and ending with 2014” after “beginning
15 with 2000”.

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

20 (A) in paragraph (1)(A), by adding at the
21 end the following: “There shall be two separate
22 conversion factors for each year beginning with
23 2026, one for items and services furnished by
24 a qualifying APM participant (as defined in
25 section 1833(z)(2)) (referred to in this sub-

1 section as the ‘qualifying APM conversion fac-
2 tor’) and the other for other items and services
3 (referred to in this subsection as the ‘nonquali-
4 fying APM conversion factor’), equal to the re-
5 spective conversion factor for the previous year
6 (or, in the case of 2026, equal to the single con-
7 version factor for 2025) multiplied by the up-
8 date established under paragraph (20) for such
9 respective conversion factor for such year.”;

10 (B) in paragraph (1)(D), by inserting “(or,
11 beginning with 2026, applicable conversion fac-
12 tor)” after “single conversion factor”; and

13 (C) by striking paragraph (16) and insert-
14 ing the following new paragraphs:

15 “(16) UPDATE FOR JANUARY THROUGH JUNE
16 OF 2015.—Subject to paragraphs (7)(B), (8)(B),
17 (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B),
18 and (15)(B), in lieu of the update to the single con-
19 version factor established in paragraph (1)(C) that
20 would otherwise apply for 2015 for the period begin-
21 ning on January 1, 2015, and ending on June 30,
22 2015, the update to the single conversion factor
23 shall be 0.0 percent.

24 “(17) UPDATE FOR JULY THROUGH DECEMBER
25 OF 2015.—The update to the single conversion factor

1 established in paragraph (1)(C) for the period begin-
2 ning on July 1, 2015, and ending on December 31,
3 2015, shall be 0.5 percent.

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

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

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

19 (3) MEDPAC REPORTS.—

20 (A) INITIAL REPORT.—Not later than July
21 1, 2017, the Medicare Payment Advisory Com-
22 mission shall submit to Congress a report on
23 the relationship between—

24 (i) physician and other health profes-
25 sional utilization and expenditures (and the

1 rate of increase of such utilization and ex-
2 penditures) of items and services for which
3 payment is made under section 1848 of the
4 Social Security Act (42 U.S.C. 1395w-4);
5 and

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

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

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

23 (C) REPORT ON UPDATE TO PHYSICIANS'
24 SERVICES UNDER MEDICARE.—Not later than
25 July 1, 2019, the Medicare Payment Advisory

1 Commission shall submit to Congress a report
2 on—

3 (i) the payment update for profes-
4 sional services applied under the Medicare
5 program under title XVIII of the Social
6 Security Act for the period of years 2015
7 through 2019;

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

11 (iii) the effect of such update on en-
12 suring a sufficient number of providers to
13 maintain access to care by Medicare bene-
14 ficiaries; and

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

20 (b) CONSOLIDATION OF CERTAIN CURRENT LAW
21 PERFORMANCE PROGRAMS WITH NEW MERIT-BASED IN-
22 CENTIVE PAYMENT SYSTEM.—

23 (1) EHR MEANINGFUL USE INCENTIVE PRO-
24 GRAM.—

1 (A) SUNSETTING SEPARATE MEANINGFUL
2 USE PAYMENT ADJUSTMENTS.—Section
3 1848(a)(7)(A) of the Social Security Act (42
4 U.S.C. 1395w-4(a)(7)(A)) is amended—

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

8 (ii) in clause (ii)(III), by striking
9 “each subsequent year” and inserting
10 “2018”; and

11 (iii) in clause (iii)—

12 (I) in the heading, by striking
13 “AND SUBSEQUENT YEARS”;

14 (II) by striking “and each subse-
15 quent year”; and

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

19 (B) CONTINUATION OF MEANINGFUL USE
20 DETERMINATIONS FOR MIPS.—Section
21 1848(o)(2) of the Social Security Act (42
22 U.S.C. 1395w-4(o)(2)) is amended—

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

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

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

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

12 “(D) CONTINUED APPLICATION FOR PUR-
13 POSES OF MIPS.—With respect to 2019 and
14 each subsequent payment year, the Secretary
15 shall, for purposes of subsection (q) and in ac-
16 cordance with paragraph (1)(F) of such sub-
17 section, determine whether an eligible profes-
18 sional who is a MIPS eligible professional (as
19 defined in subsection (q)(1)(C)) for such year is
20 a meaningful EHR user under this paragraph
21 for the performance period under subsection (q)
22 for such year.”.

23 (2) QUALITY REPORTING.—

24 (A) SUNSETTING SEPARATE QUALITY RE-
25 PORTING INCENTIVES.—Section 1848(a)(8)(A)

1 of the Social Security Act (42 U.S.C. 1395w–
2 4(a)(8)(A)) is amended—

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

6 (ii) in clause (ii)(II), by striking “and
7 each subsequent year” and inserting “,
8 2017, and 2018”.

9 (B) CONTINUATION OF QUALITY MEAS-
10 URES AND PROCESSES FOR MIPS.—Section
11 1848 of the Social Security Act (42 U.S.C.
12 1395w–4) is amended—

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

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

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

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

24 (ii) in subsection (m)—

1 (I) by redesignating paragraph
2 (7) added by section 10327(a) of Pub-
3 lic Law 111–148 as paragraph (8);
4 and

5 (II) by adding at the end the fol-
6 lowing new paragraph:

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

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

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

16 (3) VALUE-BASED PAYMENTS.—

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

22 “(iii) APPLICATION.—The Secretary
23 shall apply the payment modifier estab-
24 lished under this subsection for items and
25 services furnished on or after January 1,

1 2015, with respect to specific physicians
2 and groups of physicians the Secretary de-
3 termines appropriate, and for services fur-
4 nished on or after January 1, 2017, with
5 respect to all physicians and groups of
6 physicians. Such payment modifier shall
7 not be applied for items and services fur-
8 nished on or after January 1, 2019.”.

9 (B) CONTINUATION OF VALUE-BASED PAY-
10 MENT MODIFIER MEASURES FOR MIPS.—Section
11 1848(p) of the Social Security Act (42 U.S.C.
12 1395w–4(p)) is amended—

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

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

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

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

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

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

6 “(1) ESTABLISHMENT.—

7 “(A) IN GENERAL.—Subject to the suc-
8 ceeding provisions of this subsection, the Sec-
9 retary shall establish an eligible professional
10 Merit-based Incentive Payment System (in this
11 subsection referred to as the ‘MIPS’) under
12 which the Secretary shall—

13 “(i) develop a methodology for assess-
14 ing the total performance of each MIPS el-
15 igible professional according to perform-
16 ance standards under paragraph (3) for a
17 performance period (as established under
18 paragraph (4)) for a year;

19 “(ii) using such methodology, provide
20 for a composite performance score in ac-
21 cordance with paragraph (5) for each such
22 professional for each performance period;
23 and

24 “(iii) use such composite performance
25 score of the MIPS eligible professional for

1 a performance period for a year to deter-
2 mine and apply a MIPS adjustment factor
3 (and, as applicable, an additional MIPS
4 adjustment factor) under paragraph (6) to
5 the professional for the year.

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

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

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

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

20 “(I) for the first and second
21 years for which the MIPS applies to
22 payments (and for the performance
23 period for such first and second year),
24 a physician (as defined in section
25 1861(r)), a physician assistant, nurse

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

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

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

23 “(I) is a qualifying APM partici-
24 pant (as defined in section
25 1833(z)(2));

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(i) IN GENERAL.—Under the MIPS:

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

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

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

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

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

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

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

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

1 “(G) ACCOUNTING FOR RISK FACTORS.—

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

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

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

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

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

7 “(i) Quality.

8 “(ii) Resource use.

9 “(iii) Clinical practice improvement
10 activities.

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

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

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

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

3 “(ii) RESOURCE USE.—For the per-
4 formance category described in subpara-
5 graph (A)(ii), the measurement of resource
6 use for such period under subsection
7 (p)(3), using the methodology under sub-
8 section (r) as appropriate, and, as feasible
9 and applicable, accounting for the cost of
10 drugs under part D.

11 “(iii) CLINICAL PRACTICE IMPROVE-
12 MENT ACTIVITIES.—For the performance
13 category described in subparagraph
14 (A)(iii), clinical practice improvement ac-
15 tivities (as defined in subparagraph
16 (C)(v)(III)) under subcategories specified
17 by the Secretary for such period, which
18 shall include at least the following:

19 “(I) The subcategory of expanded
20 practice access, such as same day ap-
21 pointments for urgent needs and after
22 hours access to clinician advice.

23 “(II) The subcategory of popu-
24 lation management, such as moni-
25 toring health conditions of individuals

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

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

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

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

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

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

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

15 “(C) ADDITIONAL PROVISIONS.—

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

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

1 ures for inpatient hospitals, for purposes of
2 the performance categories described in
3 clauses (i) and (ii) of subparagraph (A).
4 For purposes of the previous sentence, the
5 Secretary may not use measures for hos-
6 pital outpatient departments, except in the
7 case of items and services furnished by
8 emergency physicians, radiologists, and an-
9 esthesiologists.

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

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

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

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

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

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

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

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

1 subparagraph and specifying criteria
2 for such activities.

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

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

13 “(bb) specifying criteria for
14 such activities; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 subsection beginning before the first per-
2 formance period under the MIPS—

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

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

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

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

24 “(3) PERFORMANCE STANDARDS.—

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

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

12 “(i) Historical performance standards.

13 “(ii) Improvement.

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

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

24 “(5) COMPOSITE PERFORMANCE SCORE.—

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

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

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

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

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

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

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

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

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

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

1 of the highest potential score for the per-
2 formance category described in paragraph
3 (2)(A)(iii) for such performance period.

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

12 “(D) ACHIEVEMENT AND IMPROVE-
13 MENT.—

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

21 “(I) in the case of the perform-
22 ance score for the performance cat-
23 egory described in clauses (i) and (ii)
24 of paragraph (2)(A), shall take into

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

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

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

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

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

25 “(I) QUALITY.—

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

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

25 “(II) RESOURCE USE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(6) MIPS PAYMENTS.—

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

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

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

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

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

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

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

22 “(iv) in a manner such that—

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

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

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

20 “(B) APPLICABLE PERCENT DEFINED.—

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

23 “(i) for 2019, 4 percent;

24 “(ii) for 2020, 5 percent;

25 “(iii) for 2021, 7 percent; and

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

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

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

24 “(i) PERFORMANCE THRESHOLD.—
25 For each year of the MIPS, the Secretary

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

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

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

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

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

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

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

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

5 “(II) take into account—

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

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

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

22 “(i) 1, plus

23 “(ii) the sum of—

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

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

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

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

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

1 “(II) SCALING FACTOR LIMIT.—

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

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

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

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

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

12 “(iii) EXCEPTIONS.—

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

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

9 “(iv) ADDITIONAL INCENTIVE PAY-
10 MENT ADJUSTMENTS.—

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

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

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

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

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

10 “(9) PUBLIC REPORTING.—

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

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

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

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

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

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

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

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

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

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

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

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

1 organizations, regional extension centers (as de-
2 scribed in section 3012(c) of the Public Health
3 Service Act), or regional health collaboratives)
4 to offer guidance and assistance to MIPS eligi-
5 ble professionals in practices of 15 or fewer pro-
6 fessionals (with priority given to such practices
7 located in rural areas, health professional short-
8 age areas (as designated under in section
9 332(a)(1)(A) of such Act), and medically under-
10 served areas, and practices with low composite
11 scores) with respect to—

12 “(i) the performance categories de-
13 scribed in clauses (i) through (iv) of para-
14 graph (2)(A); or

15 “(ii) how to transition to the imple-
16 mentation of and participation in an alter-
17 native payment model as described in sec-
18 tion 1833(z)(3)(C).

19 “(B) FUNDING FOR TECHNICAL ASSIST-
20 ANCE.—For purposes of implementing subpara-
21 graph (A), the Secretary shall provide for the
22 transfer from the Federal Supplementary Med-
23 ical Insurance Trust Fund established under
24 section 1841 to the Centers for Medicare &
25 Medicaid Services Program Management Ac-

1 count of \$20,000,000 for each of fiscal years
2 2016 through 2020. Amounts transferred under
3 this subparagraph for a fiscal year shall be
4 available until expended.

5 “(12) FEEDBACK AND INFORMATION TO IM-
6 PROVE PERFORMANCE.—

7 “(A) PERFORMANCE FEEDBACK.—

8 “(i) IN GENERAL.—Beginning July 1,
9 2017, the Secretary—

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

17 “(II) may make available con-
18 fidential feedback to such profes-
19 sionals on the performance of such
20 professionals with respect to the per-
21 formance categories under clauses (iii)
22 and (iv) of such paragraph.

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

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

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

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

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

11 “(B) ADDITIONAL INFORMATION.—

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

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

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

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

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

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

9 “(13) REVIEW.—

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

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

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

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

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

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

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

3 (2) GAO REPORTS.—

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

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

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

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

15 (iv) provide recommendations for opti-
16 mizing the use of such technical assistance
17 funds.

18 (B) STUDY TO EXAMINE ALIGNMENT OF
19 QUALITY MEASURES USED IN PUBLIC AND PRI-
20 VATE PROGRAMS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

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

9 “(1) TECHNICAL ADVISORY COMMITTEE.—

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

15 “(B) MEMBERSHIP.—

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

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

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

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

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

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

23 “(C) TERM; VACANCIES.—

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

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

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

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

19 “(E) COMPENSATION OF MEMBERS.—

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

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

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

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

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

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

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

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

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

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

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

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

1 retary on the proposed criteria under such
2 clause.

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

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

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

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

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

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

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

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

14 “(1) PAYMENT INCENTIVE.—

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

1 aggregate payment amounts for such covered pro-
2 fessional services under this part for the pre-
3 ceding year. For purposes of the previous sen-
4 tence, the payment amount for the preceding
5 year may be an estimation for the full pre-
6 ceding year based on a period of such preceding
7 year that is less than the full year. The Sec-
8 retary shall establish policies to implement this
9 subparagraph in cases in which payment for
10 covered professional services furnished by a
11 qualifying APM participant in an alternative
12 payment model—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(D) ELIGIBLE ALTERNATIVE PAYMENT
2 ENTITY.—The term ‘eligible alternative pay-
3 ment entity’ means, with respect to a year, an
4 entity that—

5 “(i) participates in an alternative pay-
6 ment model that—

7 “(I) requires participants in such
8 model to use certified EHR tech-
9 nology (as defined in subsection
10 (o)(4)); and

11 “(II) provides for payment for
12 covered professional services based on
13 quality measures comparable to meas-
14 ures under the performance category
15 described in section 1848(q)(2)(B)(i);
16 and

17 “(ii)(I) bears financial risk for mone-
18 tary losses under such alternative payment
19 model that are in excess of a nominal
20 amount; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 practitioner organizations, and other stake-
2 holders for episode groups in addition to those
3 posted pursuant to such subparagraph, and
4 specific clinical criteria and patient characteris-
5 tics to classify patients into—

6 “(i) care episode groups; and

7 “(ii) patient condition groups.

8 “(D) DEVELOPMENT OF PROPOSED CLAS-
9 SIFICATION CODES.—

10 “(i) IN GENERAL.—Taking into ac-
11 count the information described in sub-
12 paragraph (B) and the information re-
13 ceived under subparagraph (C), the Sec-
14 retary shall—

15 “(I) establish care episode groups
16 and patient condition groups, which
17 account for a target of an estimated
18 $\frac{1}{2}$ of expenditures under parts A and
19 B (with such target increasing over
20 time as appropriate); and

21 “(II) assign codes to such
22 groups.

23 “(ii) CARE EPISODE GROUPS.—In es-
24 tablishing the care episode groups under

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

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

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

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

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

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

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

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

1 groups (and codes) posted under subparagraph
2 (E). In seeking such comments, the Secretary
3 shall use one or more mechanisms (other than
4 notice and comment rulemaking) that may in-
5 clude use of open door forums, town hall meet-
6 ings, or other appropriate mechanisms.

7 “(G) OPERATIONAL LIST OF CARE EPI-
8 SODE AND PATIENT CONDITION GROUPS AND
9 CODES.—Not later than 270 days after the end
10 of the comment period described in subpara-
11 graph (F), taking into account the comments
12 received under such subparagraph, the Sec-
13 retary shall post on the Internet website of the
14 Centers for Medicare & Medicaid Services an
15 operational list of care episode and patient con-
16 dition codes (and the criteria and characteris-
17 tics assigned to such code).

18 “(H) SUBSEQUENT REVISIONS.—Not later
19 than November 1 of each year (beginning with
20 2018), the Secretary shall, through rulemaking,
21 make revisions to the operational lists of care
22 episode and patient condition codes as the Sec-
23 retary determines may be appropriate. Such re-
24 visions may be based on experience, new infor-
25 mation developed pursuant to subsection

1 (n)(9)(A), and input from the physician spe-
2 cialty societies, applicable practitioner organiza-
3 tions, and other stakeholders, including rep-
4 resentatives of individuals entitled to benefits
5 under part A or enrolled under this part.

6 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-
7 CIANS OR PRACTITIONERS.—

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

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

1 such as a physician or applicable practitioner
2 who—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(C) MEASUREMENT OF RESOURCE USE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 “(i) Clinical care.

9 “(ii) Safety.

10 “(iii) Care coordination.

11 “(iv) Patient and caregiver experience.

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

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

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

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

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

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

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

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

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

11 “(ii) Patient experience measures.

12 “(iii) Care coordination measures.

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

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

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

1 Centers for Medicare & Medicaid Services an
2 operational plan for the development of quality
3 measures for use under the applicable provi-
4 sions. Such plan shall be updated as appro-
5 priate.

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

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

16 “(B) PRIORITIZATION.—

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

22 “(ii) CONSIDERATION.—In selecting
23 measures for development under this sub-
24 section, the Secretary shall consider—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 “(A) Subsection (q)(2)(B)(i).

17 “(B) Section 1833(z)(2)(C).

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

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

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

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

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

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

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

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

3 “(B) POLICIES RELATING TO PAYMENT.—

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

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

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

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

20 (b) EDUCATION AND OUTREACH.—

21 (1) CAMPAIGN.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (f) DEFINITIONS.—In this section:

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

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

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

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

15 (1) ADDITIONAL ANALYSES.—

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

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

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

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

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

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

4 (2) ACCESS TO CERTAIN DATA.—

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

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

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

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

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

11 (3) PROTECTION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

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

3 (7) ASSESSMENT FOR A BREACH.—

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

10 (i) an agreement between the Sec-
11 retary and a qualified entity; and

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

14 (B) ASSESSMENT.—The assessment under
15 subparagraph (A) shall be an amount up to
16 \$100 for each individual entitled to, or enrolled
17 for, benefits under part A of title XVIII of the
18 Social Security Act or enrolled for benefits
19 under part B of such title—

20 (i) in the case of an agreement de-
21 scribed in subparagraph (A)(i), for whom
22 the Secretary provided data on to the
23 qualified entity under paragraph (2); and

24 (ii) in the case of an agreement de-
25 scribed in subparagraph (A)(ii), for whom

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

3 (C) DEPOSIT OF AMOUNTS COLLECTED.—

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

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

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

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

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

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

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

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

5 (i) A provider of services.

6 (ii) A supplier.

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

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

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

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

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

1 (C) QUALIFIED ENTITY.—The term “quali-
2 fied entity” has the meaning given such term in
3 section 1874(e)(2) of the Social Security Act
4 (42 U.S.C. 1395kk(e)).

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

8 (E) SUPPLIER.—The term “supplier” has
9 the meaning given such term in section 1861(d)
10 of the Social Security Act (42 U.S.C.
11 1395x(d)).

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

15 (1) ACCESS.—

16 (A) IN GENERAL.—To the extent con-
17 sistent with applicable information, privacy, se-
18 curity, and disclosure laws, beginning July 1,
19 2016, the Secretary shall, at the request of a
20 qualified clinical data registry under section
21 1848(m)(3)(E) of the Social Security Act (42
22 U.S.C. 1395w-4(m)(3)(E)), provide the data
23 described in subparagraph (B) (in a form and
24 manner determined to be appropriate) to such
25 qualified clinical data registry for purposes of

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

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

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

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

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

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

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

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

8 (2) in paragraph (3)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(i) Their number.

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

7 “(iii) Their geographic distribution.

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

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

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

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

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

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

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

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

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

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

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

3 (B) DEFINITIONS.—In this paragraph:

4 (i) WIDESPREAD INTEROPER-
5 ABILITY.—The term “widespread inter-
6 operability” means interoperability between
7 certified EHR technology systems em-
8 ployed by meaningful EHR users under
9 the Medicare and Medicaid EHR incentive
10 programs and other clinicians and health
11 care providers on a nationwide basis.

12 (ii) INTEROPERABILITY.—The term
13 “interoperability” means the ability of two
14 or more health information systems or
15 components to exchange clinical and other
16 information and to use the information
17 that has been exchanged using common
18 standards as to provide access to longitu-
19 dinal information for health care providers
20 in order to facilitate coordinated care and
21 improved patient outcomes.

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

1 extent that the objective described in subpara-
2 graph (A) has been achieved.

3 (D) RECOMMENDATIONS IF OBJECTIVE
4 NOT ACHIEVED.—If the Secretary of Health
5 and Human Services determines that the objec-
6 tive described in subparagraph (A) has not been
7 achieved by December 31, 2018, then the Sec-
8 retary shall submit to Congress a report, by not
9 later than December 31, 2019, that identifies
10 barriers to such objective and recommends ac-
11 tions that the Federal Government can take to
12 achieve such objective. Such recommended ac-
13 tions may include recommendations—

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

17 (ii) for criteria for decertifying cer-
18 tified EHR technology products.

19 (2) PREVENTING BLOCKING THE SHARING OF
20 INFORMATION.—

21 (A) FOR MEANINGFUL USE EHR PROFES-
22 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-
23 cial Security Act (42 U.S.C. 1395w-
24 4(o)(2)(A)(ii)) is amended by inserting before
25 the period at the end the following: “, and the

1 professional demonstrates (through a process
2 specified by the Secretary, such as the use of an
3 attestation) that the professional has not know-
4 ingly and willfully taken action (such as to dis-
5 able functionality) to limit or restrict the com-
6 patibility or interoperability of the certified
7 EHR technology”.

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

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

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

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

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

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

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

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

1 retary shall submit to Congress a report on
2 mechanisms that would assist providers in com-
3 paring and selecting certified EHR technology
4 products. The report shall include information
5 on the benefits of, and resources needed to de-
6 velop and maintain, such mechanisms.

7 (4) DEFINITIONS.—In this subsection:

8 (A) The term “certified EHR technology”
9 has the meaning given such term in section
10 1848(o)(4) of the Social Security Act (42
11 U.S.C. 1395w-4(o)(4)).

12 (B) The term “meaningful EHR user” has
13 the meaning given such term under the Medi-
14 care EHR incentive programs.

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

17 (i) in the case of the Medicare pro-
18 gram under title XVIII of the Social Secu-
19 rity Act, the incentive programs under sec-
20 tion 1814(l)(3), section 1848(o), sub-
21 sections (l) and (m) of section 1853, and
22 section 1886(n) of the Social Security Act
23 (42 U.S.C. 1395f(l)(3), 1395w-4(o),
24 1395w-23, 1395ww(n)); and

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

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

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

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

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

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

1 (C) Potential implications of greater use of
2 telehealth with respect to payment and delivery
3 system transformations under the Medicare
4 program under such title XVIII and the Med-
5 icaid program under title XIX of such Act (42
6 U.S.C. 1396 et seq.).

7 (D) How the Centers for Medicare & Med-
8 icaid Services monitors payments made under
9 the Medicare program under such title XVIII to
10 providers for telehealth services.

11 (2) STUDY ON REMOTE PATIENT MONITORING
12 SERVICES.—

13 (A) IN GENERAL.—The Comptroller Gen-
14 eral of the United States shall conduct a
15 study—

16 (i) of the dissemination of remote pa-
17 tient monitoring technology in the private
18 health insurance market;

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

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

1 (iv) that evaluates the patients, condi-
2 tions, and clinical circumstances that could
3 most benefit from remote patient moni-
4 toring services; and

5 (v) that evaluates the challenges re-
6 lated to establishing appropriate valuation
7 for remote patient monitoring services
8 under the Medicare physician fee schedule
9 under section 1848 of the Social Security
10 Act (42 U.S.C. 1395w-4) in order to accu-
11 rately reflect the resources involved in fur-
12 nishing such services.

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

15 (i) REMOTE PATIENT MONITORING
16 SERVICES.—The term “remote patient
17 monitoring services” means services fur-
18 nished through remote patient monitoring
19 technology.

20 (ii) REMOTE PATIENT MONITORING
21 TECHNOLOGY.—The term “remote patient
22 monitoring technology” means a coordi-
23 nated system that uses one or more home-
24 based or mobile monitoring devices that
25 automatically transmit vital sign data or

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

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

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

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

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

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

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

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

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

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

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

1 group practice, corporation of health care pro-
2 fessionals, or hospital—

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

6 (ii) required to be so licensed, reg-
7 istered, or certified but that is exempted
8 by other statute or regulation.

9 (C) MEDICAL MALPRACTICE OR MEDICAL
10 PRODUCT LIABILITY ACTION OR CLAIM.—The
11 term “medical malpractice or medical product
12 liability action or claim” means a medical mal-
13 practice action or claim (as defined in section
14 431(7) of the Health Care Quality Improve-
15 ment Act of 1986 (42 U.S.C. 11151(7))) and
16 includes a liability action or claim relating to a
17 health care provider’s prescription or provision
18 of a drug, device, or biological product (as such
19 terms are defined in section 201 of the Federal
20 Food, Drug, and Cosmetic Act (21 U.S.C. 321)
21 or section 351 of the Public Health Service Act
22 (42 U.S.C. 262)).

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

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

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

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