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Part 1

MEDICARE PATIENT ACCESS AND QUALITY IMPROVEMENT ACT OF 2013

NOVEMBER 12, 2013.—Ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 2810]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 2810) to amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians' services, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Patient Access and Quality Improvement Act of 2013".

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

SEC. 2. REFORM OF SUSTAINABLE GROWTH RATE (SGR) AND MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(a) STABILIZING FEE UPDATES (PHASE I).—

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

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting "or a subsequent paragraph or section 1848A" after "paragraph (4)"; and

(ii) in paragraph (4)—

(I) in the heading, by striking "YEARS BEGINNING WITH 2001" and inserting "2001, 2002, AND 2003"; and

(II) in subparagraph (A), by striking "a year beginning with 2001" and inserting "2001, 2002, and 2003"; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting "through 2013" after "of each succeeding year"; and

(ii) in paragraph (2), by inserting "and ending with 2013" after "beginning with 2000".

(2) UPDATE OF RATES FOR 2014 THROUGH 2018.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

"(15) UPDATE FOR 2014 THROUGH 2018.—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 through 2018 shall be 0.5 percent.".

(b) QUALITY UPDATE INCENTIVE PROGRAM (PHASE II).—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (a), is further amended—

(A) in subsection (d), by adding at the end the following new paragraph:

"(16) UPDATE BEGINNING WITH 2019.—

"(A) IN GENERAL.—Subject to subparagraph (B), the update to the single conversion factor established in paragraph (1)(C) for each year beginning with 2019 shall be 0.5 percent.

"(B) ADJUSTMENT.—In the case of an eligible professional (as defined in subsection (k)(3)) who does not have a payment arrangement described in section 1848A(a) in effect, the update under subparagraph (A) for a year beginning with 2019 shall be adjusted by the applicable quality adjustment determined under subsection (q)(3) for the year involved."; and

(B) in subsection (i)(1)—

(i) by striking "and" at the end of subparagraph (D);

(ii) by striking the period at the end of subparagraph (E) and inserting ", and"; and

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

"(F) the implementation of subsection (q).".

(2) ENHANCING PHYSICIAN QUALITY REPORTING SYSTEM TO SUPPORT QUALITY UPDATE INCENTIVE PROGRAM.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (k)(1), in the first sentence, by inserting "and, if applicable, clinical practice improvement activities," after "quality measures";

(B) in subsection (k)(2)—

(i) in subparagraph (C)—

(I) in the subparagraph heading, by striking "AND SUBSEQUENT YEARS" and inserting "THROUGH 2018"; and

(II) in clause (i), by inserting "(before 2019)" after "subsequent year";

(ii) by redesignating subparagraph (D) as subparagraph (E);

(iii) by inserting after subparagraph (C) the following new subparagraph:

"(D) FOR 2019 AND SUBSEQUENT YEARS.—For purposes of reporting data on quality measures and, as applicable clinical practice improvement activities, for covered professional services furnished during the performance period (as defined in subsection (q)(2)(B)) with respect to 2019 and the performance period with respect to each subsequent year, subject to subsection (q)(1)(D), the quality measures and clinical practice improvement activities specified under this paragraph shall be, with respect to an eligible professional, the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under paragraph (9)(F) applicable to the peer cohort of such provider and year involved."; and

(iv) in subparagraph (E), as redesignated by subparagraph (B)(ii) of this paragraph, by striking "AND SUBSEQUENT YEARS";

(C) in subsection (k)(3)—

(i) in the paragraph heading, by striking "COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED" and inserting "DEFINITIONS"; and

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

"(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—The term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

"(D) ELIGIBLE PROFESSIONAL ORGANIZATION.—The term 'eligible professional organization' means a professional organization as defined by nationally recognized multispecialty boards of certification or equivalent certification boards.

"(E) PEER COHORT.—The term 'peer cohort' means a peer cohort identified on the list under paragraph (9)(B), as updated under clause (ii) of such paragraph.";

(D) in subsection (k)(7), by striking " and the application of paragraphs (4) and (5)" and inserting ", the application of paragraphs (4) and (5), and the implementation of paragraph (9)";

(E) by adding at the end of subsection (k) the following new paragraph:

"(9) ESTABLISHMENT OF FINAL CORE MEASURE SETS.—

"(A) IN GENERAL.—Under the system under this subsection—

"(i) for each peer cohort identified under subparagraph (B) and in accordance with this paragraph, there shall be published a final core measure set under subparagraph (F), which shall consist of quality measures and may also consist of clinical practice improvement activities, with respect to which eligible professionals shall, subject to subsection (m)(3)(C), be assessed for purposes of determining, for years beginning with 2019, the quality adjustment under subsection (q)(3) applicable to such professionals; and

"(ii) each eligible professional shall self-identify, in accordance with subparagraph (B), within such a peer cohort for purposes of such assessments.

"(B) PEER COHORTS.—The Secretary shall identify (and publish a list of) peer cohorts by which eligible professionals shall self-identify for purposes of this subsection and subsection (q) with respect to a performance period (as defined in subsection (q)(2)(B)) for a year beginning with 2019. For purposes of this subsection and subsection (q), the Secretary shall develop one or more peer cohorts for multispecialty groups, each of which shall be included as a peer cohort under this subparagraph. Such self-identification will be made through such a process and at such time as specified under the system under this subsection. Such list—

"(i) shall include, as peer cohorts, provider specialties defined by nationally recognized multispecialty boards of certification or equivalent certification boards and such other cohorts as established under this section in order to capture classifications of providers across eligible professional organizations and other practice areas, groupings, or categories; and

"(ii) shall be updated from time to time.

"(C) QUALITY MEASURES FOR CORE MEASURE SETS.—

"(i) DEVELOPMENT.—Under the system under this subsection there shall be established a process for the development of quality measures under this subparagraph for purposes of potential inclusion of such

measures in core measure sets under this paragraph. Under such process—

"(I) there shall be coordination, to the extent possible, across organizations developing such measures;

"(II) eligible professional organizations and other relevant stakeholders may submit best practices and clinical practice guidelines for the development of quality measures that address quality domains (as defined under clause (ii)) for potential inclusion in such core measure sets;

"(III) there is encouraged to be developed, as appropriate, meaningful outcome measures (or quality of life measures in cases for which outcomes may not be a valid measurement), functional status measures, and patient experience measures; and

"(IV) measures developed under this clause shall be developed, to the extent possible, in accordance with best practices and clinical practice guidelines.

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

"(I) Clinical care.

"(II) Safety.

"(III) Care coordination.

"(IV) Patient and caregiver experience.

"(V) Population health and prevention.

"(D) PROCESS FOR ESTABLISHING CORE MEASURE SETS.—

"(i) IN GENERAL.—Under the system under this subsection, for purposes of subparagraph (A), there shall be established a process to approve final core measure sets under this paragraph for peer cohorts. Each such final core measure set shall be composed of quality measures (and, as applicable, clinical practice improvement activities) with respect to which eligible professionals within such peer cohort shall report under this subsection and be assessed under subsection (q). Such process shall provide—

"(I) for the establishment of criteria, which shall be made publicly available before the request is made under clause (ii), for selecting such measures and activities for potential inclusion in such a final core measure set; and

"(II) that all peer cohorts, and to the extent practicable all quality domains, are addressed by measures and, as applicable, clinical practice improvement activities selected to be included in a core measure set under this paragraph, which may include through the use of such a measure or clinical practice improvement activity that addresses more than one such domain or cohort.

"(ii) SOLICITATION OF PUBLIC INPUT ON QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Under the process established under clause (i), relevant eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures and clinical practice improvement activities (as defined in paragraph (3)(C)) for selection under this paragraph. For purposes of the previous sentence, measures and activities may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

"(E) CORE MEASURE SETS.—

"(i) IN GENERAL.—Under the process established under subparagraph (D)(i), the Secretary—

"(I) shall select, from quality measures described in clause (ii) applicable to a peer cohort, quality measures to be included in a core measure set for such cohort;

"(II) shall, to the extent there are insufficient quality measures applicable to a peer cohort to address one or more applicable quality domains, select to be included in a core measure set for such cohort such clinical practice improvement activities described in clause (ii)(IV) as are needed and available to sufficiently address such an applicable domain with respect to such peer cohort; and

"(III) may select, to the extent determined appropriate, any additional clinical practice improvement activities described in clause (ii)(IV) applicable to a peer cohort to be included in a core measure set for such cohort.

Activities selected under this paragraph shall be selected with consideration of best practices and clinical practice guidelines identified under subparagraph (C)(i)(II).

"(ii) SOURCES OF QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—A quality measure or clinical practice improvement activity selected for inclusion in a core measure set under the process under subparagraph (D)(i) shall be—

"(I) a measure endorsed by a consensus-based entity;

"(II) a measure developed under paragraph (2)(C) or a measure otherwise applied or developed for a similar purpose under this section;

"(III) a measure developed under subparagraph (C); or

"(IV) a measure or activity submitted under subparagraph (D)(ii).

A measure or activity may be selected under this subparagraph, regardless of whether such measure or activity was previously published in a proposed rule. A measure so selected shall be evidence-based but (other than a measure described in subclause (I)) shall not be required to be consensus-based.

"(iii) TRANSPARENCY.—Before publishing in a final regulation a core measure set under clause (i) as a final core measure set under subparagraph (F), the Secretary shall—

"(I) submit for publication in applicable specialty-appropriate peer-reviewed journals such core measure set under clause (i) and the method for developing and selecting measures within such set, including clinical and other data supporting such measures, and, as applicable, the method for selecting clinical practice improvement activities included within such set; and

"(II) regardless of whether or not the core measure set or method is published in such a journal under subclause (I), provide for notice of the proposed regulation in the Federal Register, including with respect to the applicable methods and data described in subclause (I), and a period for public comment thereon.

"(F) FINAL CORE MEASURE SETS.—Not later than November 15 of the year prior to the first day of a performance period, the Secretary shall publish a final regulation in the Federal Register that includes a final core measure set (and the applicable methods and data described in subparagraph (E)(iii)(I)) for each peer cohort to be applied for such performance period.

"(G) PERIODIC REVIEW AND UPDATES.—

"(i) IN GENERAL.—In carrying out this paragraph, under the system under this subsection, there shall periodically be reviewed—

"(I) the quality measures and clinical practice improvement activities selected for inclusion in final core measure sets under this paragraph for each year such measures and activities are to be applied under this subsection or subsection (q) to ensure that such measures and activities continue to meet the conditions applicable to such measures and activities for such selection; and

"(II) the final core measure sets published under subparagraph (F) for each year such sets are to be applied to peer cohorts of eligible professionals to ensure that each applicable set continues to meet the conditions applicable to such sets before being so published.

"(ii) COLLABORATION WITH STAKEHOLDERS.—In carrying out clause (i), relevant eligible professional organizations and other relevant stakeholders may identify and submit updates to quality measures and clinical practice improvement activities selected under this paragraph for inclusion in final core measure sets as well as any additional quality measures and clinical practice improvement activities. Not later than November 15 of the year prior to the first day of a performance period, submissions under this clause shall be reviewed.

"(iii) ADDITIONAL, AND UPDATES TO, MEASURES AND ACTIVITIES.—Based on the review conducted under this subparagraph for a period, as needed, there shall be—

"(I) selected additional, and updates to, quality measures and clinical practice improvement activities selected under this paragraph for potential inclusion in final core measure sets in the same manner such quality measures and clinical practice improvement activities are selected under this paragraph for such potential inclusion;

"(II) removed, from final core measure sets, quality measures and clinical practice improvement activities that are no longer meaningful; and

"(III) updated final core measure sets published under subparagraph (F) in the same manner as such sets are approved under such subparagraph.

For purposes of this subsection and subsection (q), a final core measure set, as updated under this subparagraph, shall be treated in the same manner as a final core measure set published under subparagraph (F).

"(iv) TRANSPARENCY.—

"(I) NOTIFICATION REQUIRED FOR CERTAIN UPDATES.—In the case of an update under subclause (II) or (III) of clause (iii) that adds, materially changes, or removes a measure or activity from a measure set, such update shall not apply under this subsection or subsection (q) unless notification of such update is made available to applicable eligible professionals.

"(II) PUBLIC AVAILABILITY OF UPDATED FINAL CORE MEASURE SETS.—Subparagraph (E)(iii) shall apply with respect to measure sets updated under subclause (II) or (III) of clause (iii) in the same manner as such subparagraph applies to applicable core measure sets under subparagraph (E).

"(H) COORDINATION WITH EXISTING PROGRAMS.—The development and selection of quality measures and clinical practice improvement activities under this paragraph shall, as appropriate, be coordinated with the development and selection of existing measures and requirements, such as the development of the Physician Compare Website under subsection (m)(5)(G) and the application of resource use management under subsection (n). To the extent feasible, such measures and activities shall align with measures used by other payers and with measures and activities in use under other programs in order to streamline the process of such development and selection under this paragraph. The Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of certified EHR technology.

"(I) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations (as defined in paragraph (3)(D)) and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this paragraph.

"(J) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the development or selection of measures under this paragraph."; and

(F) in subsection (m)(3)(C)(i), by adding at the end the following new sentence: "Such process shall, beginning for 2019, treat eligible professionals in such a group practice as reporting on measures for purposes of application of subsections (q) and (a)(8)(A)(iii) if, in lieu of reporting measures under subsection (k)(2)(D), the group practice reports measures determined appropriate by the Secretary.".

(3) ESTABLISHMENT OF QUALITY UPDATE INCENTIVE PROGRAM.—

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

"(q) QUALITY UPDATE INCENTIVE PROGRAM.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish an eligible professional quality update incentive program (in this section referred to as the 'quality update incentive program') under which—

"(i) there is developed and applied, in accordance with paragraph (2), appropriate methodologies for assessing the performance of eligible professionals with respect to quality measures and clinical practice improvement activities included within the final core measure sets published under subsection (k)(9)(F) applicable to the peer cohorts of such providers;

"(ii) there is applied, consistent with the system under subsection (k), methods for collecting information needed for such assessments (which shall involve the minimum amount of administrative burden required to ensure reliable results); and

"(iii) the applicable update adjustments under paragraph (3) are determined by such assessments.

"(B) DEFINITIONS.—

"(i) ELIGIBLE PROFESSIONAL.—In this subsection, the term 'eligible professional' has the meaning given such term in subsection (k)(3), except that such term shall not include a professional who has a payment arrangement described in section 1848A(a)(1) in effect.

"(ii) PEER COHORTS; CLINICAL PRACTICE IMPROVEMENT ACTIVITIES; ELIGIBLE PROFESSIONAL ORGANIZATIONS.—In this subsection, the terms 'peer cohort', 'clinical practice improvement activity', and 'eligible professional organization' have the meanings given such terms in subsection (k)(3).

"(C) CONSULTATION WITH ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subsection.

"(D) APPLICATION AT GROUP PRACTICE LEVEL.—The Secretary shall establish a process, consistent with subsection (m)(3)(C), under which the provisions of this subsection are applied to eligible professionals in a group practice if the group practice reports measures determined appropriate by the Secretary under such subsection.

"(E) COORDINATION WITH EXISTING PROGRAMS.—The application of measures and clinical practice improvement activities and assessment of performance under this subsection shall, as appropriate, be coordinated with the application of measures and assessment of performance under other provisions of this section.

"(2) ASSESSING PERFORMANCE WITH RESPECT TO FINAL CORE MEASURE SETS FOR APPLICABLE PEER COHORTS.—

"(A) ESTABLISHMENT OF METHODS FOR ASSESSMENT.—

"(i) IN GENERAL.—Under the quality update incentive program, the Secretary shall—

"(I) establish one or more methods, applicable with respect to a performance period, to assess (using a scoring scale of 0 to 100) the performance of an eligible professional with respect to, subject to paragraph (1)(D), quality measures and clinical practice improvement activities included within the final core measure set published under subsection (k)(9)(F) applicable for the period to the peer cohort in which the provider self-identified under subsection (k)(9)(B) for such period; and

"(II) subject to paragraph (1)(D), compute a composite score for such provider for such performance period with respect to the measures and activities included within such final core measure set.

"(ii) METHODS.—Such methods shall, with respect to an eligible professional, provide that the performance of such professional shall, subject to paragraph (1)(D), be assessed for a performance period with respect to the quality measures and clinical practice improvement activities within the final core measure set for such period for the peer cohort of such professional and on which information is collected from such professional.

"(iii) WEIGHTING OF MEASURES.—Such a method may provide for the assignment of different scoring weights or, as appropriate, other factors—

"(I) for quality measures and clinical practice improvement activities;

"(II) based on the type or category of measure or activity; and

"(III) based on the extent to which a quality measure or clinical practice improvement activity meaningfully assesses quality.

"(iv) RISK ADJUSTMENT.—Such a method shall provide for appropriate risk adjustments.

"(v) INCORPORATION OF OTHER METHODS OF MEASURING PHYSICIAN QUALITY.—In establishing such methods, there shall be, as appropriate, incorporated comparable methods of measurement from physician quality incentive programs under this subsection.

"(B) PERFORMANCE PERIOD.—There shall be established a period (in this subsection referred to as a 'performance period'), with respect to a year (beginning with 2019) for which the quality adjustment is applied under paragraph (3), to assess performance on quality measures and clinical practice improvement activities. Each such performance period shall be a period of

12 consecutive months and shall end as close as possible to the beginning of the year for which such adjustment is applied.

"(3) QUALITY ADJUSTMENT TAKING INTO ACCOUNT QUALITY ASSESSMENTS.—

"(A) QUALITY ADJUSTMENT.—For purposes of subsection (d)(16), if the composite score computed under paragraph (2)(A) for an eligible professional for a year (beginning with 2019) is—

"(i) a score of 67 or higher, the quality adjustment under this paragraph for the eligible professional and year is 1 percentage point;

"(ii) a score of at least 34, but below 67, the quality adjustment under this paragraph for the eligible professional and year is zero; or

"(iii) a score below 34, the quality adjustment under this paragraph for the eligible professional and year is -1 percentage point.

"(B) NO EFFECT ON SUBSEQUENT YEARS' QUALITY ADJUSTMENTS.—Each such quality adjustment shall be made each year without regard to the quality adjustment for a previous year under this paragraph.

"(4) TRANSITION FOR NEW ELIGIBLE PROFESSIONALS.—In the case of a physician, practitioner, or other supplier that during a performance period, with respect to a year for which a quality adjustment is applied under paragraph (3), first becomes an eligible professional (and had not previously submitted claims under this title as a person, as an entity, or as part of a physician group or under a different billing number or tax identifier), the quality adjustment under this subsection applicable to such physician, practitioner, or supplier—

"(A) for such year, with respect to such first performance period, shall be zero; and

"(B) for a year, with respect to a subsequent performance period, shall be the quality adjustment that would otherwise be applied under this subsection.

"(5) FEEDBACK.—

"(A) FEEDBACK.—

"(i) ONGOING FEEDBACK.—Under the process under subsection (m)(5)(H), there shall be provided, as real time as possible, but at least quarterly, beginning not later than 6 months after the first day of the first performance period, to each eligible professional feedback—

"(I) on the performance of such provider with respect to quality measures and clinical practice improvement activities within the final core measure set published under subsection (k)(9)(F) for the applicable performance period and the peer cohort of such professional; and

"(II) to assess the progress of such professional under the quality update incentive program with respect to a performance period for a year.

"(ii) USE OF REGISTRIES AND OTHER MECHANISMS.—Feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided and based on performance received through the use of such registry, and to the extent that an eligible professional chooses not to participate in such a registry for such purposes, be provided through other similar mechanisms that allow for the provision of such feedback and receipt of such performance information.

"(B) DATA MECHANISM.—Under the quality update incentive program, there shall be developed an electronic interactive eligible professional mechanism through which such a professional may receive performance data, including data with respect to performance on the measures and activities developed and selected under this section. Such mechanism shall be developed in consultation with private payers and health insurance issuers (as defined in section 2791(b)(2) of the Public Health Service Act) as appropriate.

"(C) TRANSFER OF FUNDS.—The Secretary shall provide for the transfer of $100,000,000 from the Federal Supplementary Medical Insurance Trust Fund established in section 1841 to the Center for Medicare & Medicaid Services Program Management Account to support such efforts to develop the infrastructure as necessary to carry out subsection (k)(9) and this subsection and for purposes of section 1889(h). Such funds shall be so transferred on the date of the enactment of this subsection and shall remain available until expended.".

(B) INCENTIVE TO REPORT UNDER QUALITY UPDATE INCENTIVE PROGRAM.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking "With respect to" and inserting "Subject to clause (iii), with respect to"; and

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

"(iii) APPLICATION TO ELIGIBLE PROFESSIONALS NOT REPORTING.—With respect to covered professional services (as defined in subsection (k)(3)) furnished by an eligible professional during 2019 or any subsequent year, if the eligible professional does not submit data for the performance period (as defined in subsection (q)(2)(B)) with respect to such year on, subject to subsection (q)(1)(D), the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under subsection (k)(9)(F) applicable to the peer cohort of such provider, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to 95 percent (in lieu of the applicable percent) of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph). The Secretary shall develop a minimum per year caseload threshold, with respect to eligible professionals, and the previous sentence shall not apply to eligible professionals with a caseload for a year below such threshold for such year.".

(C) EDUCATION ON QUALITY UPDATE INCENTIVE PROGRAM.—Section 1889 of the Social Security Act (42 U.S.C. 1395zz) is amended by adding at the end the following new subsection:

"(h) QUALITY UPDATE INCENTIVE PROGRAM.—Under this section, information shall be disseminated to educate and assist eligible professionals (as defined in section 1848(k)(3)) about the quality update incentive program under section 1848(q) and quality measures under section 1848(k)(9) through multiple approaches, including a national dissemination strategy and outreach by medicare contractors.".

(4) CONFORMING AMENDMENTS.—

(A) TREATMENT OF SATISFACTORILY REPORTING PQRS MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by striking "For 2014 and subsequent years" and inserting "For each of 2014 through 2018".

(B) COORDINATING ENHANCED PQRS REPORTING WITH EHR.—Section 1848(o)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(B)(iii)) is amended by striking "subsection (k)(2)(C)" and inserting "subparagraph (C) or (D) of subsection (k)(2)".

(C) COORDINATING PQRS REPORTING PERIOD WITH QUALITY UPDATE INCENTIVE PROGRAM PERFORMANCE PERIOD.—Section 1848(m)(6)(C) of the Social Security Act (42 U.S.C. 1395w–4(m)(6)(C)) is amended—

(i) in clause (i), by striking "and (iii)" and inserting ", (iii), and (iv)"; and

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

"(iv) COORDINATION WITH QUALITY UPDATE INCENTIVE PROGRAM.—For 2019 and each subsequent year the reporting period shall be coordinated with the performance period under subsection (q)(2)(B).".

(D) COORDINATING EHR REPORTING WITH QUALITY UPDATE INCENTIVE PROGRAM PERFORMANCE PERIOD.—Section 1848(o)(5)(B) of the Social Security Act (42 U.S.C. 1395w–4(o)(5)(B)) is amended by adding at the end the following: "Beginning for 2019, the EHR reporting period shall be coordinated with the performance period under subsection (q)(2)(B).".

(c) ADVANCING ALTERNATIVE PAYMENT MODELS.—

(1) IN GENERAL.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395w–4 et seq.) is amended by adding at the end the following new section:

"SEC. 1848A. ADVANCING ALTERNATIVE PAYMENT MODELS.

"(a) PAYMENT MODEL CHOICE PROGRAM.—Payment for covered professional services (as defined in section 1848(k)) that are furnished by an eligible professional (as defined in such section) under an Alternative Payment Model specified on the list under subsection (h) (in this section referred to as an 'eligible APM') shall be made under this title in accordance with the payment arrangement under such model. In applying the previous sentence, such a professional with such a payment arrangement in effect, shall be deemed for purposes of section 1848(a)(8) to be satisfactorily submitting data on quality measures for such covered professional services.

"(b) PROCESS FOR IMPLEMENTING ELIGIBLE APMS.—

"(1) IN GENERAL.—For purposes of subsection (a) and in accordance with this section, the Secretary shall establish a process under which—

"(A) a contract is entered into, in accordance with paragraph (2);

"(B) proposals for potential Alternative Payment Models are submitted in accordance with subsection (c);

"(C) Alternative Payment Models so proposed are recommended, in accordance with subsection (d), for testing and evaluation, including through the demonstration program under subsection (e), and approval under subsection (f);

"(D) applicable Alternative Payment Models are tested and evaluated under such demonstration program;

"(E) models are implemented as eligible APMs in accordance with subsection (f); and

"(F) a comprehensive list of all eligible APMs is made publicly available, in accordance with subsection (h), for application under subsection (a).

"(2) CONTRACT WITH APM CONTRACTING ENTITY.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the Secretary shall identify and have in effect a contract with an independent entity that has appropriate expertise to carry out the functions applicable to such entity under this section. Such entity shall be referred to in this section as the 'APM contracting entity'.

"(B) TIMING FOR FIRST CONTRACT.—The Secretary shall enter into the first contract under subparagraph (A) to be in effect January 1, 2019.

"(C) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)) shall be used to enter into a contract under subparagraph (A).

"(c) SUBMISSION OF PROPOSED ALTERNATIVE PAYMENT MODELS.—Beginning not later than 90 days after the date the Secretary enters into a contract under subsection (b)(2) with the APM contracting entity, physicians, eligible professional organizations, health care provider organizations, and other entities may submit to the APM contracting entity proposals for Alternative Payment Models for application under this section. Such a proposal of a model shall include suggestions for measures to be used under subsection (e)(1)(B) for purposes of evaluating such model. In reviewing submissions under this subsection for purposes of making recommendations under subsection (d)(1), the contracting entity shall focus on submissions for such models that are intended to improve care coordination and quality for patients through modifying the manner in which physicians and other providers are paid under this title.

"(d) RECOMMENDATION BY APM CONTRACTING ENTITY OF PROPOSED MODELS.—

"(1) RECOMMENDATION.—

"(A) RECOMMENDATIONS TO SECRETARY.—

"(i) IN GENERAL.—Under the process under subsection (b), the APM contracting entity shall at least quarterly recommend, in accordance with clause (ii), to the Secretary—

"(I) Alternative Payment Models submitted under subsection (c) to be tested and evaluated through a demonstration program under subsection (e); and

"(II) Alternative Payment Models submitted under subsection (c) to be implemented under subsection (f) without testing and evaluation through such a demonstration program.

Such a recommendation under subclause (I) may be made with respect to a model for which a waiver would be required under paragraph (2). Any reference in this subsection to an Alternative Payment Model under this clause is a reference to such model as may be modified under clause (iii).

"(ii) REQUIREMENTS.—In recommending an Alternative Payment Model under clause (i), each of the following shall apply:

"(I) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(I) only if the entity determines that the model satisfies the criteria described in subparagraph (B), including the criteria described in subparagraph (B)(iv).

"(II) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(II) only if the entity determines that the model satisfies the criteria described in subparagraph (C), including the criteria described in subparagraph (C)(iii).

"(III) The APM contracting entity shall include with the recommended Alternative Payment Model recommendations for rules of coordination described in clause (v).

"(iii) MODIFICATIONS BY APM CONTRACTING ENTITY.—For purposes of this subparagraph, to the extent necessary to meet the applicable requirements of clause (ii), the APM contracting entity may modify an Alternative Payment Model submitted under subsection (c) to ensure that the model would—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of care without increasing spending under this title.

"(iv) FORMS OF MODIFICATIONS.—Such a modification under clause (iii) may include one or more of the following:

"(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

"(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that the requirement described in subclause (I) or (II) is satisfied.

"(III) A change to the rules of coordination described in clause (v).

"(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

"(V) Such other change as the contracting entity may specify.

"(v) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(I) IN GENERAL.—Rules of coordination described in this clause for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

"(II) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

"(III) APPLICATION TO NON-APM PAYMENT.—In applying such rules of coordination for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

"(B) CRITERIA FOR RECOMMENDING MODELS FOR DEMONSTRATION.—For purposes of subparagraph (A)(ii)(I), the criteria described in this subparagraph, with respect to an Alternative Payment Model, are each of the following:

"(i) The model has been supported by meaningful clinical and nonclinical data, with respect to a sufficient population sample, that indicates the model would be successful at addressing each of the abilities described in clause (iv).

"(ii)(I) In the case of a model that has already been evaluated and supported by data with respect to a population of individuals enrolled under this part, if the model were evaluated under the demonstration under subsection (e) such a population would represent a sufficient number of individuals enrolled under this part to ensure a meaningful evaluation of the likely effect of expanding the demonstration.

"(II) In the case of a model that has not been so evaluated and supported by data with respect to such a population, the population that would be furnished services under such model if the model were evaluated under the demonstration under subsection (e) would represent a sufficient number of individuals enrolled under this part to ensure a meaningful evaluation of the likely effect of expanding the demonstration.

"(iii) Such model, including if tested and evaluated under the demonstration under subsection (e), would not deny or limit the coverage or provision of benefits under this title for applicable individuals.

"(iv) The proposal for such model demonstrates—

"(I) the significant likelihood to successfully manage the cost of furnishing items and services under this title so as to not result

in expenditures under this title being greater than expenditures under this title if the APM were not implemented; and

"(II) the ability to maintain or improve the overall quality of patient care provided to individuals enrolled under this part.

"(v) The model provides for a payment arrangement—

"(I) that specifies the items and services covered under the arrangement and specifies rules of coordination described in subparagraph (A)(v) between the items and services covered under the arrangement and other items and services not covered under the arrangement;

"(II) in the case such payment arrangement does not provide for payment under the fee schedule under section 1848 for such items and services furnished by such eligible professionals, that provides for a payment adjustment based on meaningful EHR use comparable to such adjustment that would otherwise apply under section 1848; and

"(III) that provides for a payment adjustment based on quality measures comparable to such adjustment that would otherwise apply under section 1848.

"(C) CRITERIA FOR RECOMMENDING MODELS FOR APPROVAL WITHOUT EVALUATION UNDER DEMONSTRATION.—For purposes of subparagraph (A)(ii)(II), the criteria described in this subparagraph, with respect to an Alternative Payment Model, is that the model has already been tested and evaluated for a sufficient enough period and through such testing and evaluation the model was shown—

"(i) to have satisfied the criteria described in each of clauses (i), (ii), (iii), and (v) of subparagraph (B); and

"(ii)(I) to have reduced spending under this title without reducing the quality of care; or

"(II) to have improved the quality of patient care without increasing such spending.

"(D) TRANSPARENCY AND DISCLOSURES.—

"(i) DISCLOSURES.—Not later than 90 days after receipt of a submission of a model under subsection (c) by the APM contracting entity, the APM contracting entity shall submit to the Secretary and the model submitter and make publicly available a notification on whether or not, and if so how, the model meets criteria for recommending such model under subparagraph (A), including whether or not such model requires a waiver under paragraph (2). In the case that the APM contracting entity determines not to recommend such model under this paragraph, such notification shall include an explanation of the reasons for not making such a recommendation. Any information made publicly available pursuant to the previous sentence shall not include proprietary data.

"(ii) SUBMISSION OF RECOMMENDED MODELS.—The APM contracting entity shall at least quarterly submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services the following:

"(I) The models recommended under subparagraph (A)(i)(I), including any such models that require a waiver under paragraph (2), and the data and analyses on such recommended models that support the criteria described in subparagraph (B).

"(II) The models recommended under subparagraph (A)(i)(II) and the data and analyses on such recommended models that support the criteria described in subparagraph (C).

"(iii) EXPLANATION FOR NO RECOMMENDATIONS.—For any year beginning with 2015 that the APM contracting entity does not recommend any models under subparagraph (A)(i), the entity shall instead satisfy this clause by submitting to the Secretary and making publicly available an explanation for not having any such recommendations.

"(iv) JUSTIFICATIONS FOR RECOMMENDATIONS.—In submitting data and analyses under subclause (I) or (II) of clause (ii) with respect to a model, the APM contracting entity shall include a specific explanation of how the model would (and recommendations for ensuring that the model will) meet the criteria described in subparagraph (B) or (C), respectively.

"(v) CONFIRMATION OF SPENDING ESTIMATES BY CMS CHIEF ACTUARY.—For each Alternative Payment Model described in subclause (I) or (II)

of clause (ii), the Chief Actuary of the Centers for Medicare & Medicaid Services shall submit to the Secretary a determination of whether or not the Chief Actuary confirms that the model satisfies the criterion described in subparagraph (B)(iv)(I) or (C)(ii), respectively.

"(2) MODELS REQUIRING WAIVER APPROVAL.—

"(A) IN GENERAL.—In the case that an Alternative Payment Model recommended under paragraph (1)(A)(i) would require a waiver from any requirement under this title, in determining approval of such model, the Secretary may make such a waiver solely in order for such model to be tested and evaluated under the demonstration program.

"(B) APPROVAL.—Not later than 180 days after the date of the receipt of such submission for a model, the Secretary shall notify the APM contracting entity and the entity submitting such model under subsection (c) whether or not such a waiver for such model is approved and the reason for any denial of such a waiver.

"(e) DEMONSTRATION.—

"(1) IN GENERAL.—Subject to paragraphs (5), (6), and (7), the Secretary may conduct a demonstration program, with respect to an Alternative Payment Model approved under paragraph (2), under which participating APM providers shall be paid under this title in accordance with the payment arrangement under such model and such model shall be evaluated by the independent evaluation entity under paragraph (4). The duration of a demonstration program under this subsection, with respect to such a model, shall be 3 years.

"(2) APPROVAL BY SECRETARY OF MODELS FOR DEMONSTRATION.—

"(A) IN GENERAL.—Not later than 180 days after the date of receipt of a submission under subsection (d)(1)(D)(ii), with respect to an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I), the Secretary shall—

"(i) review the basis for such recommendation in order to assess, taking into account the determination of the Chief Actuary under subsection (d)(1)(D)(v) with respect to such model, if the model is significantly likely to—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of care without increasing spending under this title;

"(ii) assess whether the model is significantly likely to result in participation under such model of a sufficient number of those eligible professionals for whom the model was designed consistent with clause (i) to be able to evaluate the likely effect of expanding the demonstration; and

"(iii) approve such model for a demonstration program under this subsection, including as modified under subparagraph (B), only if the Secretary determines—

"(I) the model is significantly likely to satisfy the criterion described in subclause (I) or (II) of clause (i);

"(II) the model is significantly likely to result in the participation of a sufficient number of eligible professionals described in clause (ii);

"(III) the model applies rules of coordination described in subparagraph (C) applicable to such model; and

"(IV) the model satisfies the criteria described in subsection (d)(1)(B).

The Secretary shall periodically make available a list of such models approved under clause (iii).

"(B) MODIFICATIONS BY SECRETARY.—

"(i) BEFORE APPROVAL.—For purposes of subparagraph (A), the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I) to ensure that the model meets the requirements described in subparagraph (A)(iii). Such a modification may include one or more of the following:

"(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

"(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

"(III) A change to the rules of coordination described in subparagraph (C).

"(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

"(V) Such other change as the Secretary may specify.

"(ii) TERMINATION OR MODIFICATION DURING DEMONSTRATION.—The Secretary shall terminate or modify the design and implementation of an Alternative Payment Model approved under subparagraph (A)(iii) for a demonstration program, after testing has begun, unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under this title, certifies) that the model is expected to continue to satisfy the requirements described in such paragraph relating to quality of care and reduced spending. Such termination may occur at any time after such testing has begun and before completion of the testing.

"(C) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(i) IN GENERAL.—Rules of coordination described in this subparagraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

"(ii) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

"(iii) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

"(3) PARTICIPATING APM PROVIDERS.—

"(A) IN GENERAL.—To participate under a demonstration program under this subsection, with respect to an Alternative Payment Model, an eligible professional shall enter into a contract with the Administrator of the Centers for Medicare & Medicaid Services under this subsection. For purposes of this section, such an eligible professional who so participates under such an Alternative Payment Model in this section is referred to as a 'participating APM provider'.

"(B) REQUIREMENTS.—The Secretary shall establish criteria for eligible professionals to enter into contracts under this paragraph for purposes of participation under a demonstration program with respect to an Alternative Payment Model. Such criteria shall ensure participation under such model of a sufficient number of eligible professionals for whom the model was designed in order to satisfy the criterion described in paragraph (2)(A)(iii)(II).

"(4) REPORTING AND EVALUATION.—

"(A) INDEPENDENT EVALUATION ENTITY.—Under this subsection, the Secretary shall enter into a contract with an independent entity to evaluate Alternative Payment Models under demonstration programs under this subsection based on appropriate measures specified under subparagraph (B). In this section, such entity shall be referred to as the 'independent evaluation entity'. Such contract shall be entered into in a timely manner so as to ensure evaluation of an Alternative Payment Model under a demonstration program under this subsection may begin as soon as possible after the model is approved under paragraph (2).

"(B) PERFORMANCE MEASURES.—For purposes of this subsection, the Secretary shall specify—

"(i) measures to evaluate Alternative Payment Models under demonstration programs under this subsection, which may include measures suggested under subsection (c) and shall be sufficient to allow for a comprehensive assessment of such a model; and

"(ii) quality measures on which participating APM providers shall report, which shall be similar to measures applicable under section 1848(k).

"(C) REPORTING REQUIREMENTS.—A contract entered into with a participating APM provider under paragraph (3) shall require such provider to report on appropriate measures specified under subparagraph (B).

"(D) PERIODIC REVIEW.—The independent evaluation entity shall periodically review and analyze and submit such analysis to the Secretary and the participating APM providers involved data reported under subparagraph (C) and such other data as deemed necessary to evaluate the model.

"(E) FINAL EVALUATION.—Not later than 6 months after the date of completion of a demonstration program, the independent evaluation entity shall submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services (and make publicly available) a report on each model evaluated under such program. Such report shall include—

"(i) outcomes on the clinical and claims data received through such program with respect to such model;

"(ii) recommendations on—

"(I) whether or not such model should be implemented as an eligible APM under this section; or

"(II) whether or not the evaluation of such model under the demonstration program should be extended or expanded;

"(iii) the justification for each such recommendation described in clause (ii); and

"(iv) in the case of a recommendation to implement such model as an eligible APM, recommendations on standardized rules for purposes of such implementation.

"(5) APPROVAL OF EXTENDING EVALUATION UNDER DEMONSTRATION.—Not later than 90 days after the date of receipt of a submission under paragraph (4)(E), the Secretary shall, including based on a recommendation submitted under such paragraph, determine whether an Alternative Payment Model may be extended or expanded under the demonstration program.

"(6) TERMINATION.—The Secretary shall terminate a demonstration program for a model under this subsection unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies), after testing has begun, that the model is expected to—

"(A) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under this title;

"(B) reduce spending under this title without reducing the quality of care; or

"(C) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

"(7) FUNDING.—

"(A) IN GENERAL.—There are appropriated, from amounts in the Federal Supplementary Medical Insurance Trust Fund under section 1841 not otherwise appropriated and as of the date of the enactment of this section, $2,000,000,000 for the purposes described in subparagraph (B), of which no more than 2.5 percent may be used for the purpose described in clause (iii) of such subparagraph. Amounts appropriated under this subparagraph shall be available until expended.

"(B) PURPOSES.—Amounts appropriated under subparagraph (A) shall be used for—

"(i) payments for items and services furnished by participating APM providers under an Alternative Payment Model under a demonstration program under this subsection that—

"(I) would not otherwise be eligible for payment under this title; or

"(II) exceed the amount of payment that would otherwise be made for such items and services under this title if such items and services were not furnished under such demonstration program;

"(ii) the evaluations provided for under this section of models under such a demonstration program;

"(iii) payment to the APM contracting entity for carrying out its duties under this section; and

"(iv) for otherwise carrying out this subsection.

"(C) LIMITATION.—The amounts appropriated under subparagraph (A) are the only amounts authorized or appropriated to carry out the purposes described in subparagraph (B).

"(f) IMPLEMENTATION OF RECOMMENDED MODELS AS ELIGIBLE APMS.—

"(1) ASSESSMENT.—With respect to each Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I), the Secretary shall review the basis for such recommendation and assess and determine, in consultation with the Chief Actuary of the Centers for Medicare & Medicaid Services, whether the model is significantly likely to continue to result in meeting the criterion described in subsection (e)(2)(A)(iii)(I), with or without a modification described in paragraph (5).

"(2) IMPLEMENTATION THROUGH RULEMAKING.—

"(A) PUBLICATION OF NPRM.—If the Secretary determines that such a model is significantly likely to meet such criterion, the Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a notice of proposed rulemaking to implement such model, including as modified under paragraph (5).

"(B) COMMENTS BY MEDPAC.—Not later than 90 days after the date of issuance of such notice with respect to a model, the Medicare Payment Advisory Commission shall submit comments on the proposed rule for such model to Congress and to the Secretary. Such comments shall include an evaluation of the reports from the contracting entity and independent evaluation entity on such model regarding the model's impact on expenditures and quality of care under this title.

"(C) FINAL RULE AND CONDITIONS.—The Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a final notice implementing such proposed rule, including as modified under paragraph (5), as an eligible APM only if—

"(i) the Secretary determines that such model is expected to—

"(I) reduce spending under this title without reducing the quality of care; or

"(II) improve the quality of patient care without increasing spending;

"(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such model would reduce (or would not result in any increase in) spending under this title;

"(iii) the Secretary determines that such model would not deny or limit the coverage or provision of benefits under this title for applicable individuals;

"(iv) the Secretary determines that the model is significantly likely to result in the participation of a sufficient number of appropriate eligible professionals for whom the model was designed in order to satisfy the criterion described in subsection (d)(2)(A)(iii)(II);

"(v) the Secretary determines that the model applies rules of coordination described in paragraph (6); and

"(vi) the Secretary determines that model meets such other criteria as the Secretary may determine.

"(3) APPLICABLE PHYSICIAN FEE SCHEDULE RULEMAKING PROCESS.—For purposes of paragraph (2), in the case of an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I)—

"(A) on or before April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of that year of the fee schedule amounts under this section for the succeeding year; or

"(B) after April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of the following year of the fee schedule amounts under this section for the second succeeding year.

"(4) JUSTIFICATION FOR DISAPPROVALS.—In the case that an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I) is not implemented as an eligible APM under this subsection, the Secretary shall make publicly available the rational, in detail, for such decision.

"(5) MODIFICATIONS BY SECRETARY.—For purposes of this subsection, the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I) to ensure that the model meets the requirements under paragraph (1)(B). Such a modification may include one or more of the following:

"(A) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

"(B) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

"(C) A change to the rules of coordination described in paragraph (6).

"(D) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

"(E) Such other change as the Secretary may specify.

"(6) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(A) IN GENERAL.—Rules of coordination described in this paragraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

"(B) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

"(C) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

"(g) PERIODIC REVIEW AND TERMINATION.—

"(1) PERIODIC REVIEW.—In the case of an Alternative Payment Model that has been implemented, the Secretary and the Chief Actuary of the Centers for Medicare & Medicaid Services shall review such model every 3 years to determine (and certify, in the case of the Chief Actuary and spending under this title), for the previous 3 years, whether the model has—

"(A) reduced the quality of care, or

"(B) increased spending under this title,

compared to the quality of care or spending that would have resulted if the model had not been implemented.

"(2) TERMINATION.—

"(A) QUALITY OF CARE REDUCTION TERMINATION.—If based upon such review the Secretary determines under paragraph (1)(A) that the model has reduced the quality of care, the Secretary may terminate such model.

"(B) SPENDING INCREASE TERMINATION.—Unless such Chief Actuary certifies under paragraph (1)(B) that the expenditures under this title under the model do not exceed the expenditures that would otherwise have been made if the model had not been implemented for the period involved, the Secretary shall terminate such model.

"(h) DISSEMINATION OF ELIGIBLE APMS.—Under this section there shall be established a process for specifying, and making publicly available a list of, all eligible APMs, which shall include at least those implemented under subsection (f) and demonstrations carried out with respect to payments under section 1848 through authority in existence as of the day before the date of the enactment of this section. Under such process such list shall be periodically updated and, beginning with January 1, 2015, and annually thereafter, such list shall be published in the Federal Register.".

(2) CONFORMING AMENDMENT.—Section 1848(a)(1) of the Social Security Act (42 U.S.C. 1395w–4(a)(1)) is amended by striking "shall instead" and inserting "shall, subject to section 1848A, instead".

(d) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

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

"(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

"(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

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

"(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

"(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

"(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

"(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

"(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

"(I) for 2017, is 5/6; and

"(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

"(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

"(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

"(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

"(i) The rest-of-State payment locality.

"(ii) Payment locality 3.

"(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.".

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking "The term" and inserting "Except as provided in subsection (e)(6)(D), the term".

(e) RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.—

(1) ELIGIBLE PHYSICIANS REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)) is amended by adding at the end the following new paragraph:

"(8) PHYSICIAN REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—

"(A) IN GENERAL.—The Secretary shall implement a system for the periodic reporting by physicians of data on the accuracy of relative values under this subsection, such as data relating to service volume and time. Such data shall be submitted in a form and manner specified by the Secretary and shall, as appropriate, incorporate data from existing sources of data, patient scheduling systems, cost accounting systems, and other similar systems.

"(B) IDENTIFICATION OF REPORTING COHORT.—Not later than January 1, 2015, the Secretary shall establish a mechanism for physicians to participate under the reporting system under this paragraph, all of whom shall collectively be referred to under this paragraph as the 'reporting group'. The reporting group shall include physicians across settings that collectively represent a range of specialties and practitioner types, furnish a range of physicians' services, and serve a range of patient populations.

"(C) INCENTIVE TO REPORT.—Under the system under this paragraph, the Secretary may provide for such payments under this part to physicians included in the reporting group as the Secretary determines appropriate to compensate such physicians for reporting data under the system. Such pay-

ments shall be provided in such form and manner as specified by the Secretary. In carrying out this subparagraph, reporting by such a physician under this paragraph shall not be treated as the furnishing of physicians' services for purposes of applying this section.

"(D) FUNDING.—To carry out this paragraph (other than with respect to payments made under subparagraph (C)), in addition to funds otherwise appropriated, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of $1,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.".

(2) RELATIVE VALUE ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

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

"(M) ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

"(i) IN GENERAL.—Only with respect to fee schedules established for 2016, 2017, and 2018 (and not for subsequent years), the Secretary shall—

"(I) identify, based on the data reported under paragraph (8) and other relevant data, misvalued services for which adjustments to the relative values established under this paragraph would result in a reduction in expenditures under the fee schedule under this section, with respect to such year, of not more than 1 percent of the projected amount of expenditures under such fee schedule for such year; and

"(II) make such adjustments for each such year so as only to result in such a reduction for such year.

"(ii) NO EFFECT ON SUBSEQUENT YEARS.—A reduction under this subparagraph for a year shall not affect any reduction for any subsequent year.

"(iii) RULE OF CONSTRUCTION RELATING TO UNDERVALUED CODES.—Nothing in this subparagraph shall be construed as preventing the Secretary from increasing the relative values for codes that are undervalued.".

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

"(VIII) REDUCTIONS FOR MISVALUED PHYSICIANS' SERVICES.—Reduced expenditures attributable to subparagraph (M) for fiscal years 2016, 2017, and 2018.".

(3) DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—The Secretary of Health and Human Services shall make publicly available the data used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register, v. 77, n. 222, November 16, 2012, pages 68891-69380 under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

SEC. 3. EXPANDING AVAILABILITY OF MEDICARE DATA.

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

(1) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning with 2014, notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, a qualified entity may use data received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), for additional non-public analyses (as determined appropriate by the Secretary of Health and Human Services) or provide or sell such data to registered or authorized users and subscribers, including to providers of services and suppliers, for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(2) DEFINITIONS.—In this section:

(A) The term "qualified entity" has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).

(B) The terms "supplier" and "provider of services" have the meanings given such terms in subsections (d) and (u), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

(b) ACCESS TO MEDICARE DATA TO PROVIDERS OF SERVICES AND SUPPLIERS TO FACILITATE DEVELOPMENT OF ALTERNATIVE PAYMENT MODELS AND TO QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—Consistent with applicable laws and regulations with respect to privacy and other relevant matters, the Secretary shall provide Medicare claims data (in a form and manner determined to be appropriate) to—

(1) qualified entities, that may share with providers of services and suppliers that are registered or authorized users or subscribers, for non-public use including to facilitate the development of new models of care (including development of Alternate Payment Models under section 1848A of the Social Security Act, models for small group specialty practices, and care coordination models); and

(2) qualified clinical data registries under section 1848(m)(3)(E)) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)) for purposes of linking such data with clinical outcomes data and performing and disseminating risk-adjusted, scientifically valid analysis and research to support quality improvement or patient safety, provided that any public reporting of identifiable provider data shall only be conducted with prior consent of such provider.

SEC. 4. ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.

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

"(8) ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.—

"(A) IN GENERAL.—In order to promote the coordination of care by an applicable provider (as defined in subparagraph (B)) for individuals with complex chronic care needs who are furnished items and services by multiple physicians and other suppliers and providers of services, the Secretary shall—

"(i) develop one or more HCPCS codes for complex chronic care management services for individuals with complex chronic care needs; and

"(ii) for such services furnished on or after January 1, 2015, by an applicable provider, make payment (as the Secretary determines to be appropriate) under the fee schedule under this section using such HCPCS codes.

"(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)) or a physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)) who—

"(i) is certified as a medical home (by achieving an accreditation status of level 3 by the National Committee for Quality Assurance);

"(ii) is recognized as a patient-centered specialty practice by the National Committee for Quality Assurance;

"(iii) has received equivalent certification (as determined by the Secretary); or

"(iv) meets such other comparable qualifications as the Secretary determines to be appropriate.

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

"(D) SINGLE APPLICABLE PROVIDER PAYMENT.—In carrying out this paragraph, the Secretary shall only make payment to a single applicable provider for complex chronic care management services furnished to an individual.".

SEC. 5. MISCELLANEOUS.

(a) SOLICITATIONS, RECOMMENDATIONS, AND REPORTS.—

(1) SOLICITATION FOR RECOMMENDATIONS ON EPISODES OF CARE DEFINITION.—The Administrator of the Centers for Medicare & Medicaid Services shall request eligible professional organizations (as defined in section 1848(k)(3) of the Social Security Act (42 U.S.C. 1395w–4(k)(3))) and other relevant stakeholders to submit recommendations for defining non-acute related episodes of care for purposes of applying such definition under subsections (k) and (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and section 1848A of such Act, as added by subsections (b) and (c) of section 2.

(2) SOLICITATION FOR RECOMMENDATIONS ON PROVIDER FEE SCHEDULE PAYMENT BUNDLES.—

(A) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall solicit from eligible professional organizations (as defined in section 1848(k)(3) of the Social Security Act (42 U.S.C. 1395w–4(k)(3))) recommendations for payment bundles for chronic conditions and expensive, high volume services for which payment is made under title XVIII of such Act.

(B) REPORT TO CONGRESS.—Not later than 24 months after the date of the enactment of this Act, the Administrator shall submit to Congress a report on proposals for such payment bundles.

(3) REPORTS ON MODIFIED PFS SYSTEM AND PAYMENT SYSTEM ALTERNATIVES.—

(A) BIANNUAL PROGRESS REPORTS.—Not later than January 15, 2016, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress and post on the public Internet website of the Centers for Medicare & Medicaid Services a biannual progress report—

(i) on the implementation of paragraph (9) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)), as added by section 2(b)(2), and the quality update incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by section 2(b)(3);

(ii) that includes an evaluation of such paragraph and such quality update incentive program and recommendations with respect to such program and appropriate update mechanisms; and

(iii) on the actions taken to promote and fulfill the identification of eligible APMs under section 1848A of the Social Security Act, as added by section 2(c), for application under such section 1848A.

(B) GAO AND MEDPAC REPORTS.—

(i) GAO REPORT ON INITIAL STAGES OF PROGRAM.—The Comptroller General of the United States shall submit to Congress a report for 2019 and each subsequent year analyzing the extent to which the system under section 1848(k)(9) of the Social Security Act (42 U.S.C. 1395w–4(k)(9)) and such quality update incentive program under section 1848(q) of the Social Security Act, as added by section 2(b) is successfully satisfying performance objectives, including with respect to—

(I) the process for developing and selecting measures and activities under subsection (k)(9) of section 1848 of such Act (42 U.S.C. 1395w–4);

(II) the process for assessing performance against such measures and activities under subsection (q) of such section; and

(III) the adequacy of the measures and activities so selected.

(ii) EVALUATION BY GAO AND MEDPAC ON IMPLEMENTATION OF QUALITY UPDATE INCENTIVE PROGRAM.—

(I) GAO.—The Comptroller General of the United States shall evaluate the initial phase of the quality update incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and shall submit to Congress, not later than 2019, a report with recommendations for improving such quality update incentive program.

(II) MEDPAC.—In the course of its March Report to Congress on Medicare payment policy, MedPAC shall analyze the initial phase of such quality update incentive program and make recommendations, as appropriate, for improving such quality update incentive program.

(iii) MEDPAC REPORT ON PAYMENT SYSTEM ALTERNATIVES.—

(I) IN GENERAL.—Not later than June 15, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report that analyzes multiple options for alternative payment models in lieu of section 1848 of the Social Security Act (42 U.S.C. 1395w–4). In analyzing such models, the Medicare Payment Advisory Commission shall examine at least the following models:

(aa) Accountable care organization payment models.

(bb) Primary care medical home payment models.

(cc) Bundled or episodic payments for certain conditions and services.

(dd) Gainsharing arrangements

(II) ITEMS TO BE INCLUDED.—Such report shall include information on how each recommended new payment model will achieve maximum flexibility to reward high quality, efficient care.

(C) TRACKING EXPENDITURE GROWTH AND ACCESS.—Beginning in 2015, the Chief Actuary of the Centers for Medicare & Medicaid Services shall track expenditure growth and beneficiary access to physicians' services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and shall post on the public Internet website of the Centers for Medicare & Medicaid Services annual reports on such topics.

(4) REPORT ON CLINICAL DECISION SUPPORT MECHANISMS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the extent to which clinical decision support mechanisms and other provider support tools could be used to further program objectives under section 1848 of the Social Security Act (42 U.S.C. 1395w–4)) and recommendation for how such mechanisms and tools should be so used.

(b) RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDER STANDARDS OF CARE.—

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

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

(A) The term "Federal health care provision" means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I and subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), and titles XVIII and XIX of the Social Security Act.

(B) The term "health care provider" means any individual or entity—

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

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

(C) The term "medical malpractice or medical liability action or claim" means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) The term "State" includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) NO PREEMPTION.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title III of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

PURPOSE AND SUMMARY

H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013," was introduced on July 24, 2013, by Rep. Michael Burgess (R–TX), and referred to the Committee on Energy and Commerce.

The legislation would repeal the sustainable growth rate (SGR) and reform Medicare payments for physicians' services. Additionally, H.R. 2810 further would improve the quality of care in the Medicare program by allowing de-identified data to be used by medical providers to improve the delivery of care, would ensure that payments by Federal programs for the provision of care could not be used to establish the standard of care in a medical liability case, and for other purposes.

BACKGROUND AND NEED FOR LEGISLATION

When Medicare was implemented in 1966, providers were paid according to the Customary, Prevailing, and Reasonable (CPR) system.[1] However, incentives inherent in this system led to rapid increases in both the price and volume of services under the program, and by the mid-1970s, prevailing fees under the program were linked to the Medicare Economic Index (MEI). This change was intended to limit charge inflation for physician services and was largely successful in that regard, but it placed no controls on the volume of services that physicians were paid for under the program.

In the Omnibus Budget Reconciliation Act (OBRA, P.L. 101–239) of 1989, Congress created a new system of physician payments based on the resource-based relative value scale (RBRVS). The RBRVS system attempted to link physician payment to the resources, or "inputs," that were used in providing medical services. In an attempt to control total spending for physicians' services driven by volume increases, OBRA also tied the annual update of the fee schedule to the trend in total spending for physicians' services relative to a target that was based on historical trends in volume. This method, effective in 1992, became known as the Medicare Volume Performance Standard (VPS), which would be replaced because there was concern that it did sufficiently constrain the growth in volume of services in the Medicare program and the instability of its update formula.

In 1997, the Balanced Budget Act (BBA, P.L. 105–33) replaced VPS with the SGR system. Unlike the VPS, the SGR target is tied to growth in the nation's gross domestic product per capita and adjusts physician payments by a factor that reflects cumulative spending relative to the target. While the SGR targets are not limits on expenditures, they represent a predictable and, what was intended to be, a sustainable trajectory for cumulative spending on Medicare physician services from April 1996 forward. However, much like the MEI before it, the system did not account for the volume of services provided and quickly led to a series of required annual cuts.

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. Created after enactment of the OBRA, the fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity necessary to provide the service), practice expenses, and malpractice costs (the RBRVS). The relative values are adjusted for geographic variation in costs. The adjusted relative values then are converted into a dollar payment amount by a conversion factor.

The conversion factor calculation for physician fees is updated annually based on (1) the Medicare Economic Index (MEI), which measures the weighted average annual price changes to the inputs needed to produce physician services, (2) the Update Adjustment Factor (UAF), used to equate actual and target (allowed) expendi-

[1] In the CPR system, physicians were paid the lowest of three possible fees, (1) the actual charge submitted, (2) the fee customarily charged by a particular physician, or (3) the prevailing fee charged by physicians in a given locality.

tures, and (3) allowed expenditures, equal to the actual expenditures updated by the SGR.

The SGR sets both the cumulative and allowed expenditures under the UAF formula and consists of the following components: (1) the estimated percentage changes in physician fees, (2) the estimated percentage changes in the number of fee-for-service beneficiaries, (3) the estimated percentage growth in real gross domestic product (GDP) (10-year moving average), (4) the estimated percentage changes resulting from changes in laws and regulations.[2]

Under the SGR, physician fees are adjusted up or down to meet the targeted spending levels. Actual expenditures are compared to targets, starting with the base year of 1996. After the base year, expenditure targets are calculated for each year based on increases in population, input prices, GDP, and changes in law and regulation. Actual expenditures are compared to both cumulative and annual expenditure targets, and the difference between targeted and actual spending is converted into updates to physician fees. If cumulative physician expenditures are below the expenditure target, then an annual update is calculated based on several variables including the Medicare Economic Index (MEI).[3] However, when cumulative physician expenditures exceed the expenditure target, the SGR system reduces the annual update factor (and therefore, all physician reimbursements under the fee schedule) to attempt to bring cumulative expenditures in line with the target.[4]

Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, the SGR, has resulted in a reduction in the reimbursement rates (or a "negative update"). With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions.[5] However, these legislative overrides specified that annual increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, and the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. If the SGR is not reformed or overridden, physicians face a 24.4% reduction in the conversion factor for the fee schedule update on January 1, 2014.[6] Overriding the expected cuts will cost $131.9 billion.

There are several flaws with the existing approach to payments for physicians' services in Medicare.

By design, the SGR treats all spending on physicians' services the same—excesses beyond the target result in reductions in future fees, and surpluses below the targets result in increases in future fees. Those calculations are done on a national basis, so individual

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[2] *Medicare Physician Payment Updates and The Sustainable Growth Rate (SGR) System*, The Congressional Research Service, February 2013.

[3] Created in 1975, the MEI is an inflation index similar to the Consumer Price Index that includes the prices of inputs required for the production of physician services including the physician's time, the cost of hiring employees such as technicians and clerical staff, rent, medical equipment, supplies, and drugs.

[4] For a detailed discussion of the workings of the sustainable growth rate mechanism, see *The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates*, Congressional Budget Office, September 2006, (online at http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf).

[5] *Medicare Physician Payment Updates and The Sustainable Growth Rate (SGR) System*, The Congressional Research Service, February 2013.

[6] MedPAC June 2013: *Report to the Congress: Medicare and the Health Care Delivery System.*

physicians and practitioners are actually rewarded for increasing the volume of services they provide even as their actions contribute to future SGR cuts. MedPAC notes "a main flaw of the current SGR system is its inability to differentiate by individual provider; it neither rewards physicians who restrain unnecessary volume growth nor penalizes those who contribute most to inappropriate volume increases."[7] MedPAC also noted that "the Commission determined that the SGR system is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. This system, which links annual updates to cumulative expenditures since 1996, has failed to restrain volume growth and, in fact, may have exacerbated it."[8]

The SGR targets apply to the total nationwide physician costs and not individual actions. Therefore, the reductions required if total spending exceeds the target spending amount apply equally to high quality providers as low quality providers. Those who are efficient are penalized the same as those who order excessive services.

The SGR targets are indifferent to appropriate increases in utilization of services. From 2000 to 2012, MedPAC found that Medicare spending for physician services increased by 72%—much more rapidly than payment rate updates and the MEI over the same period, and MedPAC noted that the "[g]rowth in the volume of services contributed much more to the rapid increase in Medicare spending than payment rate updates."[9] Yet, the SGR targets did not appropriately take into account the potential for volume growth. With an emphasis on total spending, such a system is indifferent to the needs of patients and has the potential to reduce physician payment rates due to the overall health care needs of Medicare seniors. Such a system has the potential to erode the rate of physician reimbursement to such an extent that it could encourage some physicians to limit the number of Medicare beneficiaries they treat or exit the program altogether.

The past three years have seen a dramatic slowing in the rate of increase of Medicare per beneficiary costs, estimated at 0.4% in 2012 and an average of 1.9% over the past three years.[10] Despite this recent slowing in cost growth and the Congressional Budget Office's (CBO) revised 2013 Medicare baseline projections, changing demographics and aging of the population, projected to increase the number of Medicare beneficiaries from 50 million today to almost 90 million by 2040, necessitate strategies to control costs while not compromising patient outcomes or shifting additional burdens to beneficiaries. Even if per-capita beneficiary costs remain stable relative to GDP, the increase in the number of beneficiaries will drive cost growth. Based on CBO estimates, the aging of the population

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[7] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 2, page 74, March 2011, (online at http://www.medpac.gov/documents/Mar11_EntireReport.pdf).

[8] MedPAC Report To Congress March 2012, page 89.

[9] Medicare Payment Advisory Commission, Data Book: Health Care Spending and the Medicare Program, June 2013.

[10] R. Kronick and R. Po, *Growth in Medicare Spending Per Beneficiary Continues to Hit Historic Lows*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (Jan. 7, 2013) (online at http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.pdf).

is expected to account for 60% of the growth in Federal health expenditures over the next 25 years.[11]

Some have pointed to the SGR as one tool to constrain the cost of the program. On this point the Committee disagrees. The SGR has only been allowed to reduce the required provider rates once, in 2002. Ever since, even proposed cuts would have been offset with new spending, which has nullified the SGR's effectiveness as a cost containment tool.

Further, the Committee finds that the continued presence of the SGR has forestalled other reforms that might improve the quality and value of the Medicare physician benefit for beneficiaries, physicians, and CMS. A number of recent reports have documented the challenges and opportunities provided by a transformed health care delivery system. The Institute of Medicine's (IOM) recent report, Best Care at Lower Cost,[12] acknowledges that our current system is falling short with regard to quality, outcomes, costs, and equity. Payment policies have a strong influence on how care is delivered and how well new knowledge and models of care are accepted. Implementing and ensuring high value care "requires restructuring incentives to reward the best outcomes for patients."[13] The IOM estimates that poor quality and care inefficiencies account for 75,000 lost lives and $750 billion (30% of 2009 total health care costs) in wasted expenditures annually. Therefore, the Committee believes that the time to repeal the SGR and move to a new payment system that rewards quality is now.

HEARINGS

On May 5, 2011, the Subcommittee on Health held a hearing entitled "The Need to Move Beyond the SGR." This hearing examined specific options for moving beyond SGR and included testimony on what a new system of payment should resemble, how quality should be measured, and paying for value over volume. The Subcommittee received testimony from Dr. Mark B. McClellan, Director of the Engelberg Center at the Brookings Institution; Dr. M. Todd Williamson, President of the Coalition of State Medical and National Specialty Societies; Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform; Dr. Cecil B. Wilson, President of the American Medical Association; Dr. David Hoyt, Executive Director of the American College of Surgeons; Dr. Roland Goertz, President of the American Academy of Family Physicians; and Dr. Michael Chernew, Professor of Health Policy at Harvard Medical School.

On July 18, 2012, the Committee held a hearing entitled "Using Innovation to Reform Medicare Physician Payment." This hearing examined proposals on how Medicare can use innovative ideas and payment/delivery models from the private sector to reform the current physician payment system. The Subcommittee received testimony from Mr. Scott Serota, President and Chief Executive Officer

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[11] Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (June 5, 2012) (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook_2.pdf).

[12] Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Sept. 6, 2012) (online at http://www.iom.edu/~/media/Files/Report%20Files/2012/Best-Care/Best%20Care%20at%20Lower%20Cost_Recs.pdf).

[13] *Id.*

for Blue Cross and Blue Shield Association; Dr. Bruce Nash, Senior VP and CMO for Capital District Physicians' Health Plan; Dr. David L. Bronson, President of the American College of Surgeons; Dr. David Hoyt, Executive Director of the American College of Surgeons; and Dr. Kavita Patel, Managing Director for Clinical Transformation and Delivery at the Brookings Institution.

On February 4, 2013, the Committee held a hearing entitled "SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System." The hearing explored the following issues: the flaws of the current volume based physician payment system as described by the Medicare Payment Advisory Committee Director Glenn Hackbarth; how to improve health through regional cooperatives and population based models; and how to measure quality and pay for value. The Subcommittee received testimony from Glenn Hackbarth, Chairman of MedPAC; Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform; Elizabeth Mitchell, CEO of the Maine Health Management Coalition; Dr. Robert Berenson, Institute Fellow at the Urban Institute; and Dr. Cheryl Damberg, Senior Policy Researcher and Professor at Pardee RAND Graduate School.

COMMITTEE CONSIDERATION

On July 22 and 23, 2013, the Subcommittee on Health met in open markup session and approved a Committee Print entitled "Medicare Patient Access and Quality Improvement Act of 2013," as amended, for full Committee consideration by a voice vote.

On July 24, 2013, Rep. Michael C. Burgess (TX) introduced H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013," which was substantially similar to the Committee Print approved by the Subcommittee on Health.

On July 30 and 31, 2013, the full Committee on Energy and Commerce met in open markup session and considered H.R. 2810. During the markup, the Committee considered an amendment offered by Mr. Burgess, which was adopted by voice vote. On July 31, 2013, the Committee ordered H.R. 2810 favorably reported to the House, as amended, by a record vote of 51 ayes and 0 nays.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. A motion by Mr. Upton to order H.R. 2810 reported to the House, as amended, was agreed to by a record vote of 51 ayes and 0 nays. The following reflects the recorded votes taken during the Committee consideration:

COMMITTEE ON ENERGY AND COMMERCE -- 113TH CONGRESS
ROLL CALL VOTE # 31

BILL: H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013"

AMENDMENT: A motion by Mr. Upton to order H.R. 2810 favorably reported to the House, as amended. (Final Passage)

DISPOSITION: **AGREED TO,** by a roll call vote of 51 yeas and 0 nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman	X		
Mr. Hall	X			Mr. Dingell	X		
Mr. Barton	X			Mr. Pallone	X		
Mr. Whitfield	X			Mr. Rush			
Mr. Shimkus	X			Ms. Eshoo	X		
Mr. Pitts	X			Mr. Engel	X		
Mr. Walden	X			Mr. Green	X		
Mr. Terry	X			Ms. DeGette	X		
Mr. Rogers	X			Mrs. Capps	X		
Mr. Murphy	X			Mr. Doyle	X		
Mr. Burgess	X			Ms. Schakowsky	X		
Mrs. Blackburn	X			Mr. Matheson	X		
Mr. Gingrey	X			Mr. Butterfield	X		
Mr. Scalise				Mr. Barrow	X		
Mr. Latta	X			Ms. Matsui	X		
Mrs. McMorris Rodgers	X			Ms. Christensen	X		
Mr. Harper	X			Ms. Castor	X		
Mr. Lance	X			Mr. Sarbanes	X		
Mr. Cassidy	X			Mr. McNerney	X		
Mr. Guthrie	X			Mr. Braley	X		
Mr. Olson	X			Mr. Welch	X		
Mr. McKinley	X			Mr. Lujan	X		
Mr. Gardner	X			Mr. Tonko	X		
Mr. Pompeo	X			Vacancy			
Mr. Kinzinger	X						
Mr. Griffith	X						
Mr. Bilirakis	X						
Mr. Johnson	X						
Mr. Long	X						
Mrs. Ellmers	X						

07/31/2013

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held hearings and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objectives of the Committee are reflected in the descriptive portions of this report, including the goal that the flawed SGR payment formula should be repealed. However, in its efforts, the Committee would like to call attention to a few items of importance with regards to the Committee's intent behind H.R. 2810.

The Committee wishes to clarify that it does not intend to compromise patient access to innovative medical technologies or treatments, such as wound care, with either its new Quality Update Incentive Program or the Payment Model Choice Program. The Committee recognizes that medical progress is dependent upon providers willingness to adopt new and better treatments and cures, whether the improvement is a new surgical technique, a better drug or vaccine, or a new medical device or diagnostic test. It is physicians' willingness to incorporate innovative treatments into decision-making about appropriate treatment options for patients that will determine whether an innovative technology or treatment will define a new standard of care.

The Committee is concerned that few physicians will want to risk receiving a low quality label or face financial penalties as a result of using an innovative treatment or technology that is too new to have been recognized as the standard of care at a given point in time, even when the new treatment could provide significant clinical benefits.

The Committee also recognizes that there is frequently a lag between the availability of an innovative technology or treatment and quality measurement development reflecting the new treatment. In implementing the provisions of the bill, the Committee expects the Secretary to establish a framework for accommodating new treatments through technical adjustments to quality scores that would apply to both the Quality Update Incentive Program and the Payment Model Choice Program.

This framework should include a process by which either a developer of an innovative medical technology, treatment, or diagnostic test, or an individual provider or alternative payment model may apply to the Secretary for adjustments to a quality measure score if this innovative treatment or technology meets certain criteria. In the case of an alternative payment model or any efficiency measure applied to eligible professionals under the Quality Update Incentive Program (QUIP), the Secretary should avoid penalizing eligible professionals for using innovative treatments or technologies that could improve quality of care and care outcomes, but would cost more than existing treatment options. In such cases, the Committee expects that the Secretary would establish a similar framework for making technical adjustments to the calculation of the efficiency score or of a calculation of shared savings.

In both instances, the Secretary should consider making adjustments to quality scores and benchmarks for new technology if (1) the new technology provides substantial clinical improvements in the diagnosis or treatment of a medical condition than the use of current therapies, and (2) lack of an adjustment would result in lower quality scores or penalize early adopters of new treatments or technologies without cause.

The Committee has concerns that some provider groups might be asked to perform and report on measures for which they have no control, or that reporting requirements promulgated by CMS might not allow their health information technology (HIT) systems to participate with those within CMS. Specifically, the Committee recognizes that pathologists are among a select group of providers that do not have frequent, or potentially any, direct contact with patients. Further, some have suggested that pathologists use HIT platforms that are different from those commonly used by other provider groups or commonly recognized by CMS. The Committee would like to stress its intent that all eligible individuals who would be subject to the QUIP should be allowed to perform and report upon quality measures and clinical improvement activities relevant to their practice. Clinical improvement activities and quality measures, such as patient experience, should take into account the appropriateness of measuring the activity against the ability of a provider to impact the outcome of the activity being measured. In addition, the ability to transmit reported data to CMS for the purposes of performance under QUIP is essential to improving the provision of care under the Medicare program, and CMS should strive to ensure that all providers are able to do so electronically.

Health information technology will play a central role in the transformation of the American healthcare system by allowing the real time availability of information at the point of care and in managing patient health and wellness. Access to this information will not only reduce unnecessary and often dangerous medical duplication, but also ensure that the most appropriate and cost effective treatment is being delivered to the patient. While technology has begun to change the way doctors provide care and patients engage in their health, we must recognize that these technologies will be unable to truly transform our health system unless they can easily locate and exchange health information.

Interoperability, or the ability for health technologies to exchange information and use information that has been exchanged, is central to the success of the alternative payment models laid out in this Committee's bipartisan effort to restructure the Medicare physician payment system. For this effort to be successful, however, more must be done to bolster interoperability. The Administration, acting through the Office of the National Coordinator for Health IT (ONC), must provide appropriate guidance to providers and to industry on its vision for interoperability and work to engage all stakeholders in adoption of those systems.

The Committee recognizes that, in order to empower providers to be successful in reporting and performing on the quality measures they develop, the Administration must adopt interoperability standards that allow every health care provider to access and use longitudinal data on the patients they treat to make evidence-based

decisions, coordinate care, and improve health outcomes as quickly as possible. The Committee believes adopting these standards by 2018 is reasonable and should be the highest priority for ONC in order to enable health care providers to measure, report, track, and perform on the quality measures and payment updates required by this legislation.

Finally, the Committee finds that this legislation leaves unanswered many questions concerning the provision of health care provider care in this country. The Committee believes that removing the looming threat of the SGR—when most in Congress see it as a broken policy—will support further reforms in the future.

It is the Committee's view that problems related to work force shortages, both among provider specialties and across the entire workforce, can be solved by supporting policies that are agnostic to the question of the provider specialty, but incentivize the desired practice itself. The Committee sought to demonstrate this through the creation of new codes for complex care management for providers certified as medical homes, whether they are primary or specialty in practice. If the Congress is going to succeed in its efforts to deliver on the Medicare promise to its seniors, it is important that Congress recognize and support the delivery of clinical care by well trained and qualified professionals, regardless of their role in the health care continuum.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 2810, the "Medicare Patient Access and Quality Improvement Act of 2013," would result in increased expenditures of $175 billion over the 2014–2023 budget window.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives, the Committee finds that H.R. 2810 contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

SEPTEMBER 13, 2013.

Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lori Housman.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

H.R. 2810—Medicare Patient Access and Quality Improvement Act of 2013

Summary: H.R. 2810 would replace the Sustainable Growth Rate (SGR) formula, which determines the annual updates to Medicare's payment rates for physician services, with new systems for establishing those payment rates. CBO estimates that enacting H.R. 2810 would increase direct spending by about $175 billion over the 2014–2023 period. Pay-as-you-go procedures apply to this legislation because it would affect direct spending. (The legislation would not affect federal revenues.)

H.R. 2810 would impose an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) by preempting state laws governing the evidentiary rules and practices of medical malpractice claims. CBO estimates that the costs of the intergovernmental mandate would be small and would not exceed the threshold established in UMRA ($75 million in 2013, adjusted annually for inflation). The bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 2810 is shown in the following table. The costs of this legislation fall within budget functions 570 (Medicare) and 550 (health).

	By fiscal year, in billions of dollars—											
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority ..	9.0	13.5	13.5	13.5	14.0	16.5	19.5	22.0	25.5	28.5	63.5	175.5
Estimated Outlays	9.0	13.5	13.5	13.5	14.0	16.5	19.5	22.0	25.5	28.5	63.5	175.5

Background and major provisions

Under current law, Medicare's payment rates for physicians' services are slated to drop by about 24 percent in January 2014. CBO projects those payment rates will increase by small amounts in most subsequent years, but will remain below 2013 levels through the 2014–2023 period.

Medicare compensates physicians for services they provide on the basis of a fee schedule that specifies payment rates for each type of covered service. Payment rates are based on a measure of the resources required to provide a given service (measured in relative

value units or RVUs), adjusted to account for geographical differences in input prices, and translated into a dollar amount by applying a "conversion factor." The SGR formula determines the annual update to the conversion factor.

Current law includes the opportunity for physicians to earn incentive payments for satisfactorily reporting quality data through the Physician Quality Reporting System (PQRS). H.R. 2810 would build upon this reporting system in replacing the SGR formula.

H.R. 2810 would replace the SGR formula with new payment systems over the next several years, phased in as follows:

- Between 2014 and 2018, the annual update to Medicare's payment rates for services on the physician fee schedule would equal 0.5 percent.
- Beginning in 2019, Medicare's payment rates for services on the physician fee schedule would be determined in two broad ways:
  - Payment rates would be based on a physician's performance in the Quality Update Incentive Program (QUIP), or
  - Physicians could choose to be paid for some or all of their Medicare services under an Alternative Payment Model (APM).

The bill also would modify payment rates in certain California counties, adjust relative value units for certain physicians' services, and require the development of payment codes that would encourage care coordination and the use of medical homes.

Quality Update Incentive Program

Under the QUIP, Medicare would continue to compensate physicians for services they provide on the basis of a fee schedule that specifies payment rates for each type of covered service. However, beginning in 2019, the annual update to the conversion factor would be 0.5 percent and the payment amount would be adjusted by a bonus or penalty based on how well a provider performed on certain quality measures and clinical practice improvement activities relative to thresholds stated in the bill. The legislation would establish a process to determine annual payment amounts as follows:

- Prior to 2019, professional societies and other stakeholders could submit to the Secretary of Health and Human Services (HHS) quality measures and clinical practice improvement activities that apply to a specific peer group (generally, a medical or surgical specialty or subspecialty).
- The Secretary would solicit public input, select measures and activities for each peer group from those that were submitted, and publish the final set prior to the "performance period."
- The Secretary would determine a performance period (probably a one-year period ending 6 to 12 months before the start of a calendar year) that would be used to measure provider performance for the purpose of determining the adjustment to the conversion factor for the next calendar year.
- Each provider would choose the appropriate peer group for his or her services and would submit data on the measures and activities selected by the Secretary for that peer group to the Centers for Medicare and Medicaid Services (CMS).

- Payment rates for providers would be determined based on their performance relative to thresholds stated in the bill. In addition to the 0.5 percent annual update to the conversion factor:
  - Providers exceeding the top threshold would get a positive 1 percent adjustment;
  - Providers not meeting the lower threshold would get a negative 1 percent adjustment; and
  - Providers between the two thresholds would not be adjusted.
  - Additionally, providers who did not submit data on the quality measures would get a negative 5 percent adjustment.

Those adjustments to the updates would be determined separately for each provider, but the Secretary could also establish a process that would apply to groups of providers practicing together. The reporting requirements and payment adjustments under the QUIP would be in addition to the existing reporting requirements and payment adjustments under the PQRS.

Alternative payment model

Beginning in 2019, the legislation also would allow providers to choose to participate in and be paid under alternative payment models. H.R. 2810 does not describe a specific payment model; rather, it would establish processes for developing and implementing such models.

The legislation would require the Secretary of HHS to enter into a contract with a private-sector organization referred to as the APM contracting entity. Provider organizations or other entities would submit proposed models to the contracting entity. The contracting entity would then recommend models to the Secretary that it concludes meet specified criteria, including that a given model would probably reduce Medicare spending without reducing the quality of care, or improve the quality of care without increasing spending. In developing those recommendations, the contracting entity would be authorized to modify a proposal to increase the likelihood that it would reduce Medicare spending or improve the quality of care. Depending on the contracting entity's assessment of the strength of the evidence that a particular model would reduce spending or improve the quality of care, the recommendation would specify that a model be either tested and evaluated in a demonstration project or incorporated directly into the Medicare program without such testing.

For models recommended for testing and evaluation through demonstration programs, the Secretary and the Chief Actuary of CMS would review the contracting entity's recommendations and analyses. The Secretary would be authorized to modify recommended models to increase the likelihood that they would reduce spending or improve the quality of care. The Secretary also would be authorized to waive requirements of title 18 of the Social Security Act, as needed, solely for testing and evaluating models under the demonstration program.

Models that undergo demonstration programs would operate for three years and would include evaluation by an independent evaluation entity. The legislation would allow the Secretary to modify or terminate during testing any demonstrations that were not

meeting or expected to meet the specified criteria; demonstrations could also be extended by the Secretary. If a particular demonstration model proves successful, is recommended by the independent evaluation entity, and is certified by the Chief Actuary as meeting specified spending criteria, it would go through a process for final approval and implementation as a new payment model within the Medicare program.

The legislation specifies similar criteria and processes for models that the contracting entity recommends implementing without testing and evaluation. The independent evaluation entity would not be involved with such models. However, before such a model can be implemented, the Chief Actuary would have to certify that a model is expected not to increase program spending (a stricter criterion than would be applied for demonstration programs).

Under either APM track, providers would enter into a contract with the Secretary to participate in a specific model. Because such models could apply only to portions of a medical practice (such as models addressing particular medical conditions), providers could participate in more than one model, as well as the QUIP.

Separately, the bill would appropriate $2 billion for items and services not eligible for Medicare payment under current law, payments for services that exceed current Medicare fee schedule amounts, and the administrative costs for the APM contracting entity and the independent evaluation entity.

Basis of estimate: Assuming enactment late in calendar year 2013, CBO estimates that enacting H.R. 2810 would increase federal direct spending by $175.5 billion over the 2014–2023 period. The bill would eliminate the cuts in payment rates that will occur under current law for services on the physician fee schedule and instead set updates to payment rates for services on the physician fee schedule at 0.5 percent a year. CBO estimates those automatic updates would increase direct spending by $63.5 billion through 2018, relative to the level of spending that CBO projects based on the payment rates under current law.

As described above, beginning in 2019, physicians would be able to choose between the QUIP and APM mechanisms and among APM options. The budgetary effects of the legislation would depend, therefore, on how the QUIP and APM mechanisms operate and on the proportion of spending affected by each of those mechanisms.

CBO considered a number of plausible outcomes in terms of both the share of Medicare spending for physicians' services that would be subject to payment under the QUIP and APM options, the relative cost of possible alternative payment models, and the savings that could accrue to the Medicare program through the use of APMs. Taking into account the effect of the automatic 0.5 percent annual update that would begin in 2014, CBO estimates that enacting the QUIP and APM mechanisms specified in H.R. 2810 would increase direct spending by about $112 billion over the 2019–2023 period. That increase, in combination with the $63.5 billion cost of the automatic updates during the 2014–2018 period, would result in a total increase in direct spending of $175.5 billion over the 2014–2023 period.

CBO expects that physicians would generally choose to participate in the payment options that offer the largest payments for the services they provide. Their choices would depend, therefore, on the alternative payment models that become available. The legislation specifies processes and safeguards for APMs, but it does not provide any details about how payment rates would be determined for services furnished by providers participating in an APM. Thus, there is significant uncertainty about the alternative payment arrangements that would be offered, how rates would be set, how many models would be adopted, how many providers would participate, how beneficiaries would be assigned, and other issues.

CBO expects that the process specified in the legislation would result in the development and adoption of multiple APMs. During the 2019–2023 period, CBO anticipates that most spending through the APM mechanism would involve models being tested through demonstrations, because relatively few models would be likely to meet the criteria for operation without first being tested in demonstration programs.

CBO expects that most of the alternative payment models that would be adopted under this legislation would increase Medicare spending. That judgment is based both on the outcomes of previous demonstration projects in Medicare and on a comparison of the process specified in this legislation for identifying and adopting APMs with the process in current law for designing, testing, and adopting innovative payment systems.

CBO's review of numerous Medicare demonstration projects found that very few succeeded in reducing Medicare spending. Those demonstrations, which often tested approaches that had been applied previously to privately insured populations, generally involved providers whose characteristics made them particularly likely to be successful at controlling spending. However, despite those relatively favorable conditions, most of those demonstrations either increased spending or had no significant effect on spending.

Based on the lessons of prior demonstrations, Congress enacted legislation that established the Center for Medicare & Medicaid Innovation (CMMI). Two elements that distinguish the process of developing new approaches under CMMI from prior demonstrations are:

- CMMI has enhanced authority to end unsuccessful demonstrations. (Ending unsuccessful demonstrations in the past was often difficult because some constituencies benefitted from increased spending. Now, the costs of unsuccessful demonstrations come out of CMMI's budget, which provides a further incentive to end unsuccessful demonstrations.)
- CMMI has the authority to expand innovations that prove to be successful at reducing costs, improving the quality of care, or both.

The structure specified by H.R. 2810 would replicate the process being followed by CMMI in many ways. Although CMMI would continue to operate under the legislation, it is likely that some models that would, under current law, be developed by CMS (with input from providers) and then tested by CMMI would, under the bill, be developed by providers (with input from CMS) and then tested or implemented as APMs. CBO expects that the greater in-

fluence of providers within the design process specified in H.R. 2810 would lead to smaller savings than would arise from the development and adoption of new approaches through the CMMI process.

In addition, CBO expects that providers would tend to choose to participate in APMs that would increase their payments from Medicare. For example, those providers whose current practice style results in Medicare spending per patient that is below the average level of spending would tend to participate in APMs that would share some of the savings relative to that average level with those providers. More generally, different APMs would tend to use different measures of success. As various APMs were developed over time, it is likely that most physicians would be able to find and participate in an alternative payment model or set of models under which the physicians would appear to be better than average.

The CMS chief actuary must concur with the judgment of the APM contracting entity that a model recommended for testing and evaluation in a demonstration program has a potential for savings. CBO anticipates that some APMs would, in fact, result in savings. On balance, however, CBO expects that the use of the APM mechanism would tend to provide physicians with rewards for good performance even when there was no change in their performance relative to current law; that effect would tend to generate higher Medicare spending than under current law.

Payments to physicians who do not participate in an APM, and payment for services provided by a physician that are not encompassed by an APM, would be made under the QUIP. Because physicians would be able to select the set of measures that would be used to determine their eligibility for the additional payment adjustment of 1 percent, CBO expects that nearly all services furnished under the QUIP beginning in 2019 would be paid at 101 percent of the amount specified on the fee schedule. To be sure, some physicians would be subject to reductions of 1 percent or 5 percent for failure to meet the performance or reporting requirements, but CBO expects most such physicians would tend to be those for whom Medicare patients make up a small share of their practices. As a result, CBO anticipates that a very small share of Medicare spending for physicians' services would be subject to those reductions.

CBO's estimate of the budgetary effects of H.R. 2810 also includes the effects of several other changes to Medicare's physician payment system specified in the legislation; those other changes would have relatively small budgetary effects. In particular, the legislation would modify payment rates in certain California counties, adjust relative value units for certain physicians' services, and require the development of payment codes that would encourage care coordination and the use of medical homes. CBO estimates those provisions would cost $0.3 billion over the 2014–2023 period.

CBO's estimate of the budgetary effects of the legislation incorporates the effects of changes in Medicare spending for services furnished in the fee-for-service sector on payments to Medicare Advantage (MA) plans and on receipts from Part B premiums paid by beneficiaries. In addition, the legislation includes the effects of

changes in Medicare payment rates on spending by the Department of Defense's TRICARE program. The MA and TRICARE effects account for about $68 billion of the total estimated increase in direct spending from the legislation over the 2014–2023 period:

- Medicare spending for the MA program would rise because the "benchmarks" that Medicare uses to determine how much the program pays for MA enrollees are adjusted for changes in Medicare spending per beneficiary in the fee-for-service sector. The benchmarks have already been set for 2014 and would not be changed under the legislation, so there would be no impact on MA spending under H.R. 2810 until 2015.
- The TRICARE program pays Medicare coinsurance and deductibles for military retirees. Those coinsurance and deductible payments would be higher under the legislation because the prices of physicians' services in Medicare would be higher.
- Beneficiaries enrolled in Part B of Medicare pay premiums that offset about 25 percent of the costs of those benefits. Such premium collections are recorded as offsetting receipts (a credit against direct spending). Therefore, about one-quarter of the increase in Medicare spending would be offset by changes in those premium receipts. However, because CBO's estimate of H.R. 2810 assumes enactment late in calendar year 2013, the 2014 costs would not be included in the premium established for calendar year 2014, but would affect premiums in several subsequent years. Over the 2015–2023 period, CBO estimates that aggregate Part B premiums receipts would rise by about $53 billion.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 2810, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON JULY 31, 2013

	By fiscal year, in billions of dollars—											
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
NET INCREASE IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	9.0	13.5	13.5	13.5	14.0	16.5	19.5	22.0	25.5	28.5	63.5	175.5

Estimated impact on state, local, and tribal governments: H.R. 2810 would shield health care providers from liability claims based on any federal guidelines or standards developed, recognized, or implemented under any health care provision of the Affordable Care Act. That provision would impose an intergovernmental mandate as defined in UMRA because it would preempt state laws that allow for the use of such guidelines or standards in medical malpractice claims. While the preemption would limit the application of state laws, CBO estimates that it would not impose significant costs and would fall well below the threshold established in UMRA

for intergovernmental mandates ($75 million in 2013, adjusted annually for inflation).

Estimated impact on the private sector: This bill contains no new private-sector mandates as defined in UMRA.

Estimate prepared by: Federal costs: Lori Housman; Impact on state, local, and tribal governments: Lisa Ramirez-Branum; Impact on the private sector: Alexia Diorio.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 2810 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting H.R. 2810 specifically directs to be completed 6 specific rule makings within the meaning of 5 U.S.C. 551.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

This Act may be cited as the "Medicare Patient Access and Quality Improvement Act of 2013."

Section 2. Reform of Sustainable Growth Rate (SGR) and Medicare payment for physicians' services

Section 2 amends section 1848 of the Social Security Act (SSA) to repeal the SGR and create a 5–year period of stable payments while development of an improved FFS physician payment system is undertaken. The annual update for participating physicians during this period will be .5%.

As part of the period of transition, the Secretary will be required to create peer cohorts that eligible professionals may use to select the measure sets they will use to determine their annual update

under the QUIP beginning in year 6. These sets can be made up of quality measures or clinical improvement activities, where appropriate. All measures and clinical improvement activities must conform to the best practices of medicine and be made public, including all clinical data and information related to the measures development. It is the Committee's intent that the clinical practice improvement activities are identified by professional organizations recognized by multispecialty boards of certification or equivalent certification boards, such as the American Board of Medical Specialties or American Osteopathic Association. Moving forward, the Secretary is charged with continually updating the measure sets to ensure they remain meaningful over time.

Beginning in year 6, physician payment updates will be determined by performance against quality measures and clinical improvement activities contained in the QUIP. Measurement periods will be 12 consecutive months in length (as close to the payment consequence year as possible) with performance in 1 year impacting payment updates for the following year. Timely performance feedback will be provided at least quarterly to eligible professionals and should reflect data that is as real-time as possible (no older than 6 months). The development of the QUIP is required to be streamlined with existing programs to reduce the regulatory burden on physicians and other eligible professionals. Similarly, it is the Committee's intent that implementation of all program provisions within this section should follow a transparent, expedient, and least administratively burdensome procedures.

There also is a new Section 1848A of the SSA creating a pathway for the testing and implementation of alternative payment models. The goal of this new pathway is to support eligible professional's additional payment options under the Payment Model Choice Program that support higher quality care and allow greater flexibility for both patients and providers. Such a pathway is not designed to recreate the Center for Medicare and Medicaid Innovation (CMMI), but to present opportunities for the broad adoption of models not allowed under CMMI or other venues. This pathway would rest upon CMS contracting with outside entities to accept and evaluate submissions and test/oversee performance demonstrations for appropriate model options. Only those that are deemed to be cost effective and high in quality would be allowed to move from the testing phase to the Secretary for possible inclusion in a list of payment options for all fee schedule providers under Medicare Part B.

Beginning in 2017, this section also improves the geographic adjustment method used to calculate provider payments in California. Currently, Medicare providers' payments are adjusted for geographic costs variations as determined by the fee schedule area in which a provider operates. To more accurately account for locality cost differences in California, this legislation requires the use of Metropolitan Statistical Areas (MSAs), as determined by the Office of Management and Budget, as the new fee schedule areas and establishes a single rest-of-State fee schedule area for those providers outside of the MSAs. From 2017 to 2021, the legislation provides for a 5-year transition for those providers included in the rest-of-State payment locality by progressively placing higher weight on the new system calculation over the previous system calculation.

This provision also allows for hold harmless protections, which prevents any provider from receiving a lower geographic payment adjustment under the new system than they would under the previous system.

Section 2 also provides for greater payment accuracy under the Medicare Part B fee schedule by which providers are currently paid. A lack of accurate and meaningful data on costs has hampered the ability of Medicare to review the accuracy of payments for services and identify what services are improperly valued. Section 5 would ensure that providers could be compensated for the cost of submitting such data and directs Medicare to identify improperly valued services under the fee schedule that would result in a net reduction of 1% of the projected amount of expenditures for a year during 2016 through 2018.

Finally, section 2 provides for greater transparency in determining recent provider payment reductions by requiring the Secretary to make publicly available the data used to establish multiple procedure payment reductions for imaging services.

Relating to demonstration programs, the Committee supports the development of new and innovative modalities of treatment, which show promise for either improved outcomes or lower costs. An estimated 6.5 million Americans suffer from chronic, hard-to-heal wounds each year. In that regard, CMS should consider initiating a pilot study on the health outcomes of new medical technologies for treating hard-to-heal wounds, including an examination of medical technologies that are not currently eligible for reimbursement in CMS programs.

Section 3. Expanding availability of Medicare data

Section 3 amends section 1874(e) of the SSA to allow qualified entities to use and disseminate de-identified Medicare claims data to authorized users for the purpose of improving the quality or provision of health care, or to support the building and testing of new models of payment under the Medicare program.

Section 4. Encouraging care coordination and medical homes

Section 4 amends 1848(b) of the SSA to require the Secretary of Health and Human Services to develop one or more codes (HCPCS) for complex chronic care management for use in caring for patients with complex chronic care needs. Providers of services under Medicare Part B must be certified as a patient-centered medical home or have received equivalent status.

Section 5. Miscellaneous

Section 5 would require a number of reports from various entities, including a report on the viability of transforming fee-for-service Medicare Part B payment into a system of bundled payments. Other reports include, a report from the Secretary, who is required to solicit feedback from provider organizations on defining non-acute care linked episodes of care, reports by GAO evaluating the QUIP and Payment Model Choice Program, and a report by the Secretary on the potential to include clinical decision support mechanisms into Medicare.

Lastly, Section 5 would create standard of care protections for patients and providers by ensuring that quality determinations for the purpose of payment by the Federal government shall not be deemed to represent the standard of care in a medical liability case.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) IN GENERAL.—Effective for all physicians' services (as defined in subsection (j)(3)) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1834(b), payment under this part [shall instead] *shall, subject to section 1848A, instead* be based on the lesser of—

(A) * * *

* * * * * * *

(8) INCENTIVES FOR QUALITY REPORTING.—

(A) ADJUSTMENT.—

(i) IN GENERAL.—[With respect to] *Subject to clause (iii), with respect to* covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of

paragraphs (3), (5), and (7), but without regard to this paragraph).

* * * * * * *

(iii) APPLICATION TO ELIGIBLE PROFESSIONALS NOT REPORTING.—With respect to covered professional services (as defined in subsection (k)(3)) furnished by an eligible professional during 2019 or any subsequent year, if the eligible professional does not submit data for the performance period (as defined in subsection (q)(2)(B)) with respect to such year on, subject to subsection (q)(1)(D), the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under subsection (k)(9)(F) applicable to the peer cohort of such provider, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to 95 percent (in lieu of the applicable percent) of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph). The Secretary shall develop a minimum per year caseload threshold, with respect to eligible professionals, and the previous sentence shall not apply to eligible professionals with a caseload for a year below such threshold for such year.

* * * * * * *

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) * * *

* * * * * * *

(8) ENCOURAGING CARE COORDINATION AND MEDICAL HOMES.—

(A) IN GENERAL.—In order to promote the coordination of care by an applicable provider (as defined in subparagraph (B)) for individuals with complex chronic care needs who are furnished items and services by multiple physicians and other suppliers and providers of services, the Secretary shall—

(i) develop one or more HCPCS codes for complex chronic care management services for individuals with complex chronic care needs; and

(ii) for such services furnished on or after January 1, 2015, by an applicable provider, make payment (as the Secretary determines to be appropriate) under the fee schedule under this section using such HCPCS codes.

(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term "applicable provider" means a physician (as defined in section 1861(r)(1)) or a physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)) who—

(i) is certified as a medical home (by achieving an accreditation status of level 3 by the National Committee for Quality Assurance);

(ii) is recognized as a patient-centered specialty practice by the National Committee for Quality Assurance;

(iii) has received equivalent certification (as determined by the Secretary); or

(iv) meets such other comparable qualifications as the Secretary determines to be appropriate.

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

(D) SINGLE APPLICABLE PROVIDER PAYMENT.—In carrying out this paragraph, the Secretary shall only make payment to a single applicable provider for complex chronic care management services furnished to an individual.

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

* * * * * * *

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) * * *

* * * * * * *

(VIII) REDUCTIONS FOR MISVALUED PHYSICIANS' SERVICES.—Reduced expenditures attributable to subparagraph (M) for fiscal years 2016, 2017, and 2018.

* * * * * * *

(M) ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

(i) IN GENERAL.—Only with respect to fee schedules established for 2016, 2017, and 2018 (and not for subsequent years), the Secretary shall—

(I) identify, based on the data reported under paragraph (8) and other relevant data, misvalued services for which adjustments to the relative values established under this paragraph would result in a reduction in expenditures under the fee schedule under this section, with respect to such year, of not more than 1 percent of the projected amount of expenditures under such fee schedule for such year; and

(II) make such adjustments for each such year so as only to result in such a reduction for such year.

(ii) NO EFFECT ON SUBSEQUENT YEARS.—A reduction under this subparagraph for a year shall not affect any reduction for any subsequent year.

(iii) RULE OF CONSTRUCTION RELATING TO UNDERVALUED CODES.—Nothing in this subparagraph shall be construed as preventing the Secretary from increasing the relative values for codes that are undervalued.

* * * * * * *

(7) PHYSICIAN REPORTING SYSTEM TO IMPROVE ACCURACY OF RELATIVE VALUES.—

(A) IN GENERAL.—The Secretary shall implement a system for the periodic reporting by physicians of data on the accuracy of relative values under this subsection, such as data relating to service volume and time. Such data shall be submitted in a form and manner specified by the Secretary and shall, as appropriate, incorporate data from existing sources of data, patient scheduling systems, cost accounting systems, and other similar systems.

(B) IDENTIFICATION OF REPORTING COHORT.—Not later than January 1, 2015, the Secretary shall establish a mechanism for physicians to participate under the reporting system under this paragraph, all of whom shall collectively be referred to under this paragraph as the "reporting group". The reporting group shall include physicians across settings that collectively represent a range of specialties and practitioner types, furnish a range of physicians' services, and serve a range of patient populations.

(C) INCENTIVE TO REPORT.—Under the system under this paragraph, the Secretary may provide for such payments under this part to physicians included in the reporting group as the Secretary determines appropriate to compensate such physicians for reporting data under the system. Such payments shall be provided in such form and manner as specified by the Secretary. In carrying out this subparagraph, reporting by such a physician under this paragraph shall not be treated as the furnishing of physicians' services for purposes of applying this section.

(D) FUNDING.—To carry out this paragraph (other than with respect to payments made under subparagraph (C)), in addition to funds otherwise appropriated, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of $1,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of 1992, speci-

fied in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4) *or a subsequent paragraph or section 1848A*) for the year involved.

* * * * * * *

(4) UPDATE FOR [YEARS BEGINNING WITH 2001] *2001, 2002, AND 2003.*—

(A) IN GENERAL.—Unless otherwise provided by law, subject to the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii) and subject to adjustment under subparagraph (F), the update to the single conversion factor established in paragraph (1)(C) for [a year beginning with 2001] *2001, 2002, and 2003* is equal to the product of—

(i) * * *

* * * * * * *

(15) UPDATE FOR 2014 THROUGH 2018.—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 through 2018 shall be 0.5 percent.

(16) UPDATE BEGINNING WITH 2019.—

(A) IN GENERAL.—Subject to subparagraph (B), the update to the single conversion factor established in paragraph (1)(C) for each year beginning with 2019 shall be 0.5 percent.

(B) ADJUSTMENT.—In the case of an eligible professional (as defined in subsection (k)(3)) who does not have a payment arrangement described in section 1848A(a) in effect, the update under subparagraph (A) for a year beginning with 2019 shall be adjusted by the applicable quality adjustment determined under subsection (q)(3) for the year involved.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) * * *

* * * * * * *

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

(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an "MSA"), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

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

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

(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following:

(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

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

(I) for 2017, is 5/6; and

(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

(D) TRANSITION AREA DEFINED.—In this paragraph, the term "transition area" means each of the following fee schedule areas for 2013:

(i) The rest-of-State payment locality.

(ii) Payment locality 3.

(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.

(f) SUSTAINABLE GROWTH RATE.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) * * *

(B) November 1 of each succeeding year *through 2013* the sustainable growth rate for such succeeding year and each of the preceding 2 years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 *and ending with 2013* shall be equal to the product of—

(A) * * *

* * * * * * *

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) * * *

* * * * * * *

(D) the establishment of geographic adjustment factors under subsection (e), [and]

(E) the establishment of the system for the coding of physicians' services under this section[.], *and*

(F) the implementation of subsection (q).

* * * * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

(2) FEE SCHEDULE AREA.—[The term] *Except as provided in subsection (e)(6)(D), the term* "fee schedule area" means a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services.

* * * * * * *

(k) QUALITY REPORTING SYSTEM.—

(1) IN GENERAL.—The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures *and, if applicable, clinical practice improvement activities,* specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

(2) USE OF CONSENSUS-BASED QUALITY MEASURES.—

(A) * * *

* * * * * * *

(C) FOR 2010 [AND SUBSEQUENT YEARS] *THROUGH 2018*.—

(i) IN GENERAL.—Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year *(before 2019)*, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

* * * * * * *

(D) FOR 2019 AND SUBSEQUENT YEARS.—For purposes of reporting data on quality measures and, as applicable clin-

ical practice improvement activities, for covered professional services furnished during the performance period (as defined in subsection (q)(2)(B)) with respect to 2019 and the performance period with respect to each subsequent year, subject to subsection (q)(1)(D), the quality measures and clinical practice improvement activities specified under this paragraph shall be, with respect to an eligible professional, the quality measures and, as applicable, clinical practice improvement activities within the final core measure set under paragraph (9)(F) applicable to the peer cohort of such provider and year involved.

[(D)**]** *(E)* OPPORTUNITY TO PROVIDE INPUT ON MEASURES FOR 2009 **[**AND SUBSEQUENT YEARS**]**.—For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.

(3) **[**COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED**]** *DEFINITIONS*.—For purposes of this subsection:

(A) * * *

* * * * * * *

(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—The term "clinical practice improvement activity" means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

(D) ELIGIBLE PROFESSIONAL ORGANIZATION.—The term "eligible professional organization" means a professional organization as defined by nationally recognized multispecialty boards of certification or equivalent certification boards.

(E) PEER COHORT.—The term "peer cohort" means a peer cohort identified on the list under paragraph (9)(B), as updated under clause (ii) of such paragraph.

* * * * * * *

(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) **[**and the application of paragraphs (4) and (5)**]***, the application of paragraphs (4) and (5), and the implementation of paragraph (9)*.

* * * * * * *

(9) ESTABLISHMENT OF FINAL CORE MEASURE SETS.—

(A) IN GENERAL.—Under the system under this subsection—

(i) for each peer cohort identified under subparagraph (B) and in accordance with this paragraph, there shall be published a final core measure set under subparagraph (F), which shall consist of quality measures and may also consist of clinical practice improvement activities, with respect to which eligible professionals shall, subject to subsection (m)(3)(C), be assessed for purposes of determining, for years beginning with 2019, the quality adjustment under subsection (q)(3) applicable to such professionals; and

(ii) each eligible professional shall self-identify, in accordance with subparagraph (B), within such a peer cohort for purposes of such assessments.

(B) PEER COHORTS.—The Secretary shall identify (and publish a list of) peer cohorts by which eligible professionals shall self-identify for purposes of this subsection and subsection (q) with respect to a performance period (as defined in subsection (q)(2)(B)) for a year beginning with 2019. For purposes of this subsection and subsection (q), the Secretary shall develop one or more peer cohorts for multispecialty groups, each of which shall be included as a peer cohort under this subparagraph. Such self-identification will be made through such a process and at such time as specified under the system under this subsection. Such list—

(i) shall include, as peer cohorts, provider specialties defined by nationally recognized multispecialty boards of certification or equivalent certification boards and such other cohorts as established under this section in order to capture classifications of providers across eligible professional organizations and other practice areas, groupings, or categories; and

(ii) shall be updated from time to time.

(C) QUALITY MEASURES FOR CORE MEASURE SETS.—

(i) DEVELOPMENT.—Under the system under this subsection there shall be established a process for the development of quality measures under this subparagraph for purposes of potential inclusion of such measures in core measure sets under this paragraph. Under such process—

(I) there shall be coordination, to the extent possible, across organizations developing such measures;

(II) eligible professional organizations and other relevant stakeholders may submit best practices and clinical practice guidelines for the development of quality measures that address quality domains (as defined under clause (ii)) for potential inclusion in such core measure sets;

(III) there is encouraged to be developed, as appropriate, meaningful outcome measures (or quality of life measures in cases for which outcomes may not be a valid measurement), functional sta-

tus measures, and patient experience measures; and

(IV) measures developed under this clause shall be developed, to the extent possible, in accordance with best practices and clinical practice guidelines.

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

(I) Clinical care.

(II) Safety.

(III) Care coordination.

(IV) Patient and caregiver experience.

(V) Population health and prevention.

(D) PROCESS FOR ESTABLISHING CORE MEASURE SETS.—

(i) IN GENERAL.—Under the system under this subsection, for purposes of subparagraph (A), there shall be established a process to approve final core measure sets under this paragraph for peer cohorts. Each such final core measure set shall be composed of quality measures (and, as applicable, clinical practice improvement activities) with respect to which eligible professionals within such peer cohort shall report under this subsection and be assessed under subsection (q). Such process shall provide—

(I) for the establishment of criteria, which shall be made publicly available before the request is made under clause (ii), for selecting such measures and activities for potential inclusion in such a final core measure set; and

(II) that all peer cohorts, and to the extent practicable all quality domains, are addressed by measures and, as applicable, clinical practice improvement activities selected to be included in a core measure set under this paragraph, which may include through the use of such a measure or clinical practice improvement activity that addresses more than one such domain or cohort.

(ii) SOLICITATION OF PUBLIC INPUT ON QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Under the process established under clause (i), relevant eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures and clinical practice improvement activities (as defined in paragraph (3)(C)) for selection under this paragraph. For purposes of the previous sentence, measures and activities may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

(E) CORE MEASURE SETS.—

(i) IN GENERAL.—Under the process established under subparagraph (D)(i), the Secretary—

(I) shall select, from quality measures described in clause (ii) applicable to a peer cohort, quality

measures to be included in a core measure set for such cohort;

(II) shall, to the extent there are insufficient quality measures applicable to a peer cohort to address one or more applicable quality domains, select to be included in a core measure set for such cohort such clinical practice improvement activities described in clause (ii)(IV) as are needed and available to sufficiently address such an applicable domain with respect to such peer cohort; and

(III) may select, to the extent determined appropriate, any additional clinical practice improvement activities described in clause (ii)(IV) applicable to a peer cohort to be included in a core measure set for such cohort.

Activities selected under this paragraph shall be selected with consideration of best practices and clinical practice guidelines identified under subparagraph (C)(i)(II).

(ii) SOURCES OF QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—A quality measure or clinical practice improvement activity selected for inclusion in a core measure set under the process under subparagraph (D)(i) shall be—

(I) a measure endorsed by a consensus-based entity;

(II) a measure developed under paragraph (2)(C) or a measure otherwise applied or developed for a similar purpose under this section;

(III) a measure developed under subparagraph (C); or

(IV) a measure or activity submitted under subparagraph (D)(ii).

A measure or activity may be selected under this subparagraph, regardless of whether such measure or activity was previously published in a proposed rule. A measure so selected shall be evidence-based but (other than a measure described in subclause (I)) shall not be required to be consensus-based.

(iii) TRANSPARENCY.—Before publishing in a final regulation a core measure set under clause (i) as a final core measure set under subparagraph (F), the Secretary shall—

(I) submit for publication in applicable specialty-appropriate peer-reviewed journals such core measure set under clause (i) and the method for developing and selecting measures within such set, including clinical and other data supporting such measures, and, as applicable, the method for selecting clinical practice improvement activities included within such set; and

(II) regardless of whether or not the core measure set or method is published in such a journal under subclause (I), provide for notice of the pro-

posed regulation in the Federal Register, including with respect to the applicable methods and data described in subclause (I), and a period for public comment thereon.

(F) FINAL CORE MEASURE SETS.—Not later than November 15 of the year prior to the first day of a performance period, the Secretary shall publish a final regulation in the Federal Register that includes a final core measure set (and the applicable methods and data described in subparagraph (E)(iii)(I)) for each peer cohort to be applied for such performance period.

(G) PERIODIC REVIEW AND UPDATES.—

(i) IN GENERAL.—In carrying out this paragraph, under the system under this subsection, there shall periodically be reviewed—

(I) the quality measures and clinical practice improvement activities selected for inclusion in final core measure sets under this paragraph for each year such measures and activities are to be applied under this subsection or subsection (q) to ensure that such measures and activities continue to meet the conditions applicable to such measures and activities for such selection; and

(II) the final core measure sets published under subparagraph (F) for each year such sets are to be applied to peer cohorts of eligible professionals to ensure that each applicable set continues to meet the conditions applicable to such sets before being so published.

(ii) COLLABORATION WITH STAKEHOLDERS.—In carrying out clause (i), relevant eligible professional organizations and other relevant stakeholders may identify and submit updates to quality measures and clinical practice improvement activities selected under this paragraph for inclusion in final core measure sets as well as any additional quality measures and clinical practice improvement activities. Not later than November 15 of the year prior to the first day of a performance period, submissions under this clause shall be reviewed.

(iii) ADDITIONAL, AND UPDATES TO, MEASURES AND ACTIVITIES.—Based on the review conducted under this subparagraph for a period, as needed, there shall be—

(I) selected additional, and updates to, quality measures and clinical practice improvement activities selected under this paragraph for potential inclusion in final core measure sets in the same manner such quality measures and clinical practice improvement activities are selected under this paragraph for such potential inclusion;

(II) removed, from final core measure sets, quality measures and clinical practice improvement activities that are no longer meaningful; and

(III) updated final core measure sets published under subparagraph (F) in the same manner as such sets are approved under such subparagraph.

For purposes of this subsection and subsection (q), a final core measure set, as updated under this subparagraph, shall be treated in the same manner as a final core measure set published under subparagraph (F).

(iv) TRANSPARENCY.—

(I) NOTIFICATION REQUIRED FOR CERTAIN UPDATES.—In the case of an update under subclause (II) or (III) of clause (iii) that adds, materially changes, or removes a measure or activity from a measure set, such update shall not apply under this subsection or subsection (q) unless notification of such update is made available to applicable eligible professionals.

(II) PUBLIC AVAILABILITY OF UPDATED FINAL CORE MEASURE SETS.—Subparagraph (E)(iii) shall apply with respect to measure sets updated under subclause (II) or (III) of clause (iii) in the same manner as such subparagraph applies to applicable core measure sets under subparagraph (E).

(H) COORDINATION WITH EXISTING PROGRAMS.—The development and selection of quality measures and clinical practice improvement activities under this paragraph shall, as appropriate, be coordinated with the development and selection of existing measures and requirements, such as the development of the Physician Compare Website under subsection (m)(5)(G) and the application of resource use management under subsection (n). To the extent feasible, such measures and activities shall align with measures used by other payers and with measures and activities in use under other programs in order to streamline the process of such development and selection under this paragraph. The Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of certified EHR technology.

(I) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations (as defined in paragraph (3)(D)) and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this paragraph.

(J) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the development or selection of measures under this paragraph.

* * * * * * *

(m) INCENTIVE PAYMENTS FOR QUALITY REPORTING.—

(1) * * *

* * * * * * *

(3) SATISFACTORY REPORTING AND SUCCESSFUL ELECTRONIC PRESCRIBER AND DESCRIBED.—

(A) * * *

* * * * * * *

(C) SATISFACTORY REPORTING MEASURES FOR GROUP PRACTICES.—

(i) IN GENERAL.—By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year, or, for purposes of subsection (a)(8), for a quality reporting period for the year) if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary. *Such process shall, beginning for 2019, treat eligible professionals in such a group practice as reporting on measures for purposes of application of subsections (q) and (a)(8)(A)(iii) if, in lieu of reporting measures under subsection (k)(2)(D), the group practice reports measures determined appropriate by the Secretary.*

* * * * * * *

(D) SATISFACTORY REPORTING MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—**[**For 2014 and subsequent years**]** *For each of 2014 through 2018*, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures under subparagraph (A) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

* * * * * * *

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

(A) * * *

* * * * * * *

(C) REPORTING PERIOD.—

(i) IN GENERAL.—Subject to clauses (ii) **[**and (iii)**]**, *(iii), and (iv)*, the term "reporting period" means—

(I) * * *

* * * * * * *

(iv) COORDINATION WITH QUALITY UPDATE INCENTIVE PROGRAM.—For 2019 and each subsequent year the reporting period shall be coordinated with the performance period under subsection (q)(2)(B).

* * * * * * *

(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

(1) * * *

(2) MEANINGFUL EHR USER.—

(A) * * *

(B) REPORTING ON MEASURES.—

(i) * * *

* * * * * * *

(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under [subsection (k)(2)(C)] *subparagraph (C) or (D) of subsection (k)(2)*.

* * * * * * *

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

(A) * * *

(B) EHR REPORTING PERIOD.—The term "EHR reporting period" means, with respect to a payment year, any period (or periods) as specified by the Secretary. *Beginning for 2019, the EHR reporting period shall be coordinated with the performance period under subsection (q)(2)(B).*

* * * * * * *

(q) QUALITY UPDATE INCENTIVE PROGRAM.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish an eligible professional quality update incentive program (in this section referred to as the "quality update incentive program") under which—

(i) there is developed and applied, in accordance with paragraph (2), appropriate methodologies for assessing the performance of eligible professionals with respect to quality measures and clinical practice improvement activities included within the final core measure sets published under subsection (k)(9)(F) applicable to the peer cohorts of such providers;

(ii) there is applied, consistent with the system under subsection (k), methods for collecting information needed for such assessments (which shall involve the minimum amount of administrative burden required to ensure reliable results); and

(iii) the applicable update adjustments under paragraph (3) are determined by such assessments.

(B) DEFINITIONS.—

(i) ELIGIBLE PROFESSIONAL.—In this subsection, the term "eligible professional" has the meaning given such term in subsection (k)(3), except that such term shall not include a professional who has a payment arrangement described in section 1848A(a)(1) in effect.

(ii) PEER COHORTS; CLINICAL PRACTICE IMPROVEMENT ACTIVITIES; ELIGIBLE PROFESSIONAL ORGANIZATIONS.—

In this subsection, the terms "peer cohort", "clinical practice improvement activity", and "eligible professional organization" have the meanings given such terms in subsection (k)(3).

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

(D) APPLICATION AT GROUP PRACTICE LEVEL.—The Secretary shall establish a process, consistent with subsection (m)(3)(C), under which the provisions of this subsection are applied to eligible professionals in a group practice if the group practice reports measures determined appropriate by the Secretary under such subsection.

(E) COORDINATION WITH EXISTING PROGRAMS.—The application of measures and clinical practice improvement activities and assessment of performance under this subsection shall, as appropriate, be coordinated with the application of measures and assessment of performance under other provisions of this section.

(2) ASSESSING PERFORMANCE WITH RESPECT TO FINAL CORE MEASURE SETS FOR APPLICABLE PEER COHORTS.—

(A) ESTABLISHMENT OF METHODS FOR ASSESSMENT.—

(i) IN GENERAL.—Under the quality update incentive program, the Secretary shall—

(I) establish one or more methods, applicable with respect to a performance period, to assess (using a scoring scale of 0 to 100) the performance of an eligible professional with respect to, subject to paragraph (1)(D), quality measures and clinical practice improvement activities included within the final core measure set published under subsection (k)(9)(F) applicable for the period to the peer cohort in which the provider self-identified under subsection (k)(9)(B) for such period; and

(II) subject to paragraph (1)(D), compute a composite score for such provider for such performance period with respect to the measures and activities included within such final core measure set.

(ii) METHODS.—Such methods shall, with respect to an eligible professional, provide that the performance of such professional shall, subject to paragraph (1)(D), be assessed for a performance period with respect to the quality measures and clinical practice improvement activities within the final core measure set for such period for the peer cohort of such professional and on which information is collected from such professional.

(iii) WEIGHTING OF MEASURES.—Such a method may provide for the assignment of different scoring weights or, as appropriate, other factors—

(I) for quality measures and clinical practice improvement activities;

(II) based on the type or category of measure or activity; and

(III) based on the extent to which a quality measure or clinical practice improvement activity meaningfully assesses quality.

(iv) RISK ADJUSTMENT.—Such a method shall provide for appropriate risk adjustments.

(v) INCORPORATION OF OTHER METHODS OF MEASURING PHYSICIAN QUALITY.—In establishing such methods, there shall be, as appropriate, incorporated comparable methods of measurement from physician quality incentive programs under this subsection.

(B) PERFORMANCE PERIOD.—There shall be established a period (in this subsection referred to as a "performance period"), with respect to a year (beginning with 2019) for which the quality adjustment is applied under paragraph (3), to assess performance on quality measures and clinical practice improvement activities. Each such performance period shall be a period of 12 consecutive months and shall end as close as possible to the beginning of the year for which such adjustment is applied.

(3) QUALITY ADJUSTMENT TAKING INTO ACCOUNT QUALITY ASSESSMENTS.—

(A) QUALITY ADJUSTMENT.—For purposes of subsection (d)(16), if the composite score computed under paragraph (2)(A) for an eligible professional for a year (beginning with 2019) is—

(i) a score of 67 or higher, the quality adjustment under this paragraph for the eligible professional and year is 1 percentage point;

(ii) a score of at least 34, but below 67, the quality adjustment under this paragraph for the eligible professional and year is zero; or

(iii) a score below 34, the quality adjustment under this paragraph for the eligible professional and year is -1 percentage point.

(B) NO EFFECT ON SUBSEQUENT YEARS' QUALITY ADJUSTMENTS.—Each such quality adjustment shall be made each year without regard to the quality adjustment for a previous year under this paragraph.

(4) TRANSITION FOR NEW ELIGIBLE PROFESSIONALS.—In the case of a physician, practitioner, or other supplier that during a performance period, with respect to a year for which a quality adjustment is applied under paragraph (3), first becomes an eligible professional (and had not previously submitted claims under this title as a person, as an entity, or as part of a physician group or under a different billing number or tax identifier), the quality adjustment under this subsection applicable to such physician, practitioner, or supplier—

(A) for such year, with respect to such first performance period, shall be zero; and

(B) for a year, with respect to a subsequent performance period, shall be the quality adjustment that would otherwise be applied under this subsection.

(5) FEEDBACK.—

(A) FEEDBACK.—

(i) ONGOING FEEDBACK.—Under the process under subsection (m)(5)(H), there shall be provided, as real time as possible, but at least quarterly, beginning not later than 6 months after the first day of the first performance period, to each eligible professional feedback—

(I) on the performance of such provider with respect to quality measures and clinical practice improvement activities within the final core measure set published under subsection (k)(9)(F) for the applicable performance period and the peer cohort of such professional; and

(II) to assess the progress of such professional under the quality update incentive program with respect to a performance period for a year.

(ii) USE OF REGISTRIES AND OTHER MECHANISMS.—Feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided and based on performance received through the use of such registry, and to the extent that an eligible professional chooses not to participate in such a registry for such purposes, be provided through other similar mechanisms that allow for the provision of such feedback and receipt of such performance information.

(B) DATA MECHANISM.—Under the quality update incentive program, there shall be developed an electronic interactive eligible professional mechanism through which such a professional may receive performance data, including data with respect to performance on the measures and activities developed and selected under this section. Such mechanism shall be developed in consultation with private payers and health insurance issuers (as defined in section 2791(b)(2) of the Public Health Service Act) as appropriate.

(C) TRANSFER OF FUNDS.—The Secretary shall provide for the transfer of $100,000,000 from the Federal Supplementary Medical Insurance Trust Fund established in section 1841 to the Center for Medicare & Medicaid Services Program Management Account to support such efforts to develop the infrastructure as necessary to carry out subsection (k)(9) and this subsection and for purposes of section 1889(h). Such funds shall be so transferred on the date of the enactment of this subsection and shall remain available until expended.

SEC. 1848A. ADVANCING ALTERNATIVE PAYMENT MODELS.

(a) PAYMENT MODEL CHOICE PROGRAM.—Payment for covered professional services (as defined in section 1848(k)) that are furnished by an eligible professional (as defined in such section) under an Alternative Payment Model specified on the list under subsection (h) (in this section referred to as an "eligible APM") shall be made under this title in accordance with the payment arrangement under

such model. In applying the previous sentence, such a professional with such a payment arrangement in effect, shall be deemed for purposes of section 1848(a)(8) to be satisfactorily submitting data on quality measures for such covered professional services.

(b) PROCESS FOR IMPLEMENTING ELIGIBLE APMS.—

(1) IN GENERAL.—For purposes of subsection (a) and in accordance with this section, the Secretary shall establish a process under which—

(A) a contract is entered into, in accordance with paragraph (2);

(B) proposals for potential Alternative Payment Models are submitted in accordance with subsection (c);

(C) Alternative Payment Models so proposed are recommended, in accordance with subsection (d), for testing and evaluation, including through the demonstration program under subsection (e), and approval under subsection (f);

(D) applicable Alternative Payment Models are tested and evaluated under such demonstration program;

(E) models are implemented as eligible APMs in accordance with subsection (f); and

(F) a comprehensive list of all eligible APMs is made publicly available, in accordance with subsection (h), for application under subsection (a).

(2) CONTRACT WITH APM CONTRACTING ENTITY.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), the Secretary shall identify and have in effect a contract with an independent entity that has appropriate expertise to carry out the functions applicable to such entity under this section. Such entity shall be referred to in this section as the "APM contracting entity".

(B) TIMING FOR FIRST CONTRACT.—The Secretary shall enter into the first contract under subparagraph (A) to be in effect January 1, 2019.

(C) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)) shall be used to enter into a contract under subparagraph (A).

(c) SUBMISSION OF PROPOSED ALTERNATIVE PAYMENT MODELS.—Beginning not later than 90 days after the date the Secretary enters into a contract under subsection (b)(2) with the APM contracting entity, physicians, eligible professional organizations, health care provider organizations, and other entities may submit to the APM contracting entity proposals for Alternative Payment Models for application under this section. Such a proposal of a model shall include suggestions for measures to be used under subsection (e)(1)(B) for purposes of evaluating such model. In reviewing submissions under this subsection for purposes of making recommendations under subsection (d)(1), the contracting entity shall focus on submissions for such models that are intended to improve care coordination and quality for patients through modifying the manner in which physicians and other providers are paid under this title.

(d) RECOMMENDATION BY APM CONTRACTING ENTITY OF PROPOSED MODELS.—

(1) RECOMMENDATION.—

(A) RECOMMENDATIONS TO SECRETARY.—

(i) IN GENERAL.—Under the process under subsection (b), the APM contracting entity shall at least quarterly recommend, in accordance with clause (ii), to the Secretary—

(I) Alternative Payment Models submitted under subsection (c) to be tested and evaluated through a demonstration program under subsection (e); and

(II) Alternative Payment Models submitted under subsection (c) to be implemented under subsection (f) without testing and evaluation through such a demonstration program.

Such a recommendation under subclause (I) may be made with respect to a model for which a waiver would be required under paragraph (2). Any reference in this subsection to an Alternative Payment Model under this clause is a reference to such model as may be modified under clause (iii).

(ii) REQUIREMENTS.—In recommending an Alternative Payment Model under clause (i), each of the following shall apply:

(I) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(I) only if the entity determines that the model satisfies the criteria described in subparagraph (B), including the criteria described in subparagraph (B)(iv).

(II) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(II) only if the entity determines that the model satisfies the criteria described in subparagraph (C), including the criteria described in subparagraph (C)(iii).

(III) The APM contracting entity shall include with the recommended Alternative Payment Model recommendations for rules of coordination described in clause (v).

(iii) MODIFICATIONS BY APM CONTRACTING ENTITY.—For purposes of this subparagraph, to the extent necessary to meet the applicable requirements of clause (ii), the APM contracting entity may modify an Alternative Payment Model submitted under subsection (c) to ensure that the model would—

(I) reduce spending under this title without reducing the quality of care; or

(II) improve the quality of care without increasing spending under this title.

(iv) FORMS OF MODIFICATIONS.—Such a modification under clause (iii) may include one or more of the following:

(I) A change to the payment arrangement under which eligible professionals participating in such

model would be paid for covered professional services furnished under such model.

(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that the requirement described in subclause (I) or (II) is satisfied.

(III) A change to the rules of coordination described in clause (v).

(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

(V) Such other change as the contracting entity may specify.

(v) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

(I) IN GENERAL.—Rules of coordination described in this clause for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

(II) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

(III) APPLICATION TO NON-APM PAYMENT.—In applying such rules of coordination for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

(B) CRITERIA FOR RECOMMENDING MODELS FOR DEMONSTRATION.—For purposes of subparagraph (A)(ii)(I), the criteria described in this subparagraph, with respect to an Alternative Payment Model, are each of the following:

(i) The model has been supported by meaningful clinical and non-clinical data, with respect to a sufficient population sample, that indicates the model would be successful at addressing each of the abilities described in clause (iv).

(ii)(I) In the case of a model that has already been evaluated and supported by data with respect to a population of individuals enrolled under this part, if the model were evaluated under the demonstration under subsection (e) such a population would represent a sufficient number of individuals enrolled under this part to ensure a meaningful evaluation of the likely effect of expanding the demonstration.

(II) In the case of a model that has not been so evaluated and supported by data with respect to such a population, the population that would be furnished services under such model if the model were evaluated under the demonstration under subsection (e) would represent a sufficient number of individuals enrolled under this part to ensure a meaningful evaluation of the likely effect of expanding the demonstration.

(iii) Such model, including if tested and evaluated under the demonstration under subsection (e), would not deny or limit the coverage or provision of benefits under this title for applicable individuals.

(iv) The proposal for such model demonstrates—

(I) the significant likelihood to successfully manage the cost of furnishing items and services under this title so as to not result in expenditures under this title being greater than expenditures under this title if the APM were not implemented; and

(II) the ability to maintain or improve the overall quality of patient care provided to individuals enrolled under this part.

(v) The model provides for a payment arrangement—

(I) that specifies the items and services covered under the arrangement and specifies rules of coordination described in subparagraph (A)(v) between the items and services covered under the arrangement and other items and services not covered under the arrangement;

(II) in the case such payment arrangement does not provide for payment under the fee schedule under section 1848 for such items and services furnished by such eligible professionals, that provides for a payment adjustment based on meaningful EHR use comparable to such adjustment that would otherwise apply under section 1848; and

(III) that provides for a payment adjustment based on quality measures comparable to such adjustment that would otherwise apply under section 1848.

(C) CRITERIA FOR RECOMMENDING MODELS FOR APPROVAL WITHOUT EVALUATION UNDER DEMONSTRATION.—For purposes of subparagraph (A)(ii)(II), the criteria described in this subparagraph, with respect to an Alternative Payment Model, is that the model has already been tested and evaluated for a sufficient enough period and through such testing and evaluation the model was shown—

(i) to have satisfied the criteria described in each of clauses (i), (ii), (iii), and (v) of subparagraph (B); and

(ii)(I) to have reduced spending under this title without reducing the quality of care; or

(II) to have improved the quality of patient care without increasing such spending.

(D) TRANSPARENCY AND DISCLOSURES.—

(i) DISCLOSURES.—Not later than 90 days after receipt of a submission of a model under subsection (c) by the APM contracting entity, the APM contracting entity shall submit to the Secretary and the model submitter and make publicly available a notification on whether or not, and if so how, the model meets criteria for recommending such model under subparagraph (A), including whether or not such model requires a waiver under paragraph (2). In the case that the APM contracting entity determines not to recommend such model under this paragraph, such notification shall include an explanation of the reasons for not making such a recommendation. Any information made publicly available pursuant to the previous sentence shall not include proprietary data.

(ii) SUBMISSION OF RECOMMENDED MODELS.—The APM contracting entity shall at least quarterly submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services the following:

(I) The models recommended under subparagraph (A)(i)(I), including any such models that require a waiver under paragraph (2), and the data and analyses on such recommended models that support the criteria described in subparagraph (B).

(II) The models recommended under subparagraph (A)(i)(II) and the data and analyses on such recommended models that support the criteria described in subparagraph (C).

(iii) EXPLANATION FOR NO RECOMMENDATIONS.—For any year beginning with 2015 that the APM contracting entity does not recommend any models under subparagraph (A)(i), the entity shall instead satisfy this clause by submitting to the Secretary and making publicly available an explanation for not having any such recommendations.

(iv) JUSTIFICATIONS FOR RECOMMENDATIONS.—In submitting data and analyses under subclause (I) or (II) of clause (ii) with respect to a model, the APM contracting entity shall include a specific explanation of how the model would (and recommendations for ensuring that the model will) meet the criteria described in subparagraph (B) or (C), respectively.

(v) CONFIRMATION OF SPENDING ESTIMATES BY CMS CHIEF ACTUARY.—For each Alternative Payment Model described in subclause (I) or (II) of clause (ii), the Chief Actuary of the Centers for Medicare & Medicaid Services shall submit to the Secretary a determination of whether or not the Chief Actuary confirms that the model satisfies the criterion described in subparagraph (B)(iv)(I) or (C)(ii), respectively.

(2) MODELS REQUIRING WAIVER APPROVAL.—

(A) IN GENERAL.—In the case that an Alternative Payment Model recommended under paragraph (1)(A)(i) would

require a waiver from any requirement under this title, in determining approval of such model, the Secretary may make such a waiver solely in order for such model to be tested and evaluated under the demonstration program.

(B) APPROVAL.—Not later than 180 days after the date of the receipt of such submission for a model, the Secretary shall notify the APM contracting entity and the entity submitting such model under subsection (c) whether or not such a waiver for such model is approved and the reason for any denial of such a waiver.

(e) DEMONSTRATION.—

(1) IN GENERAL.—Subject to paragraphs (5), (6), and (7), the Secretary may conduct a demonstration program, with respect to an Alternative Payment Model approved under paragraph (2), under which participating APM providers shall be paid under this title in accordance with the payment arrangement under such model and such model shall be evaluated by the independent evaluation entity under paragraph (4). The duration of a demonstration program under this subsection, with respect to such a model, shall be 3 years.

(2) APPROVAL BY SECRETARY OF MODELS FOR DEMONSTRATION.—

(A) IN GENERAL.—Not later than 180 days after the date of receipt of a submission under subsection (d)(1)(D)(ii), with respect to an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I), the Secretary shall—

(i) review the basis for such recommendation in order to assess, taking into account the determination of the Chief Actuary under subsection (d)(1)(D)(v) with respect to such model, if the model is significantly likely to—

(I) reduce spending under this title without reducing the quality of care; or

(II) improve the quality of care without increasing spending under this title;

(ii) assess whether the model is significantly likely to result in participation under such model of a sufficient number of those eligible professionals for whom the model was designed consistent with clause (i) to be able to evaluate the likely effect of expanding the demonstration; and

(iii) approve such model for a demonstration program under this subsection, including as modified under subparagraph (B), only if the Secretary determines—

(I) the model is significantly likely to satisfy the criterion described in subclause (I) or (II) of clause (i);

(II) the model is significantly likely to result in the participation of a sufficient number of eligible professionals described in clause (ii);

(III) the model applies rules of coordination described in subparagraph (C) applicable to such model; and

(IV) the model satisfies the criteria described in subsection (d)(1)(B).

The Secretary shall periodically make available a list of such models approved under clause (iii).

(B) MODIFICATIONS BY SECRETARY.—

(i) BEFORE APPROVAL.—For purposes of subparagraph (A), the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I) to ensure that the model meets the requirements described in subparagraph (A)(iii). Such a modification may include one or more of the following:

(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

(III) A change to the rules of coordination described in subparagraph (C).

(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

(V) Such other change as the Secretary may specify.

(ii) TERMINATION OR MODIFICATION DURING DEMONSTRATION.—The Secretary shall terminate or modify the design and implementation of an Alternative Payment Model approved under subparagraph (A)(iii) for a demonstration program, after testing has begun, unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under this title, certifies) that the model is expected to continue to satisfy the requirements described in such paragraph relating to quality of care and reduced spending. Such termination may occur at any time after such testing has begun and before completion of the testing.

(C) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

(i) IN GENERAL.—Rules of coordination described in this subparagraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

(ii) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

(iii) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

(3) PARTICIPATING APM PROVIDERS.—

(A) IN GENERAL.—To participate under a demonstration program under this subsection, with respect to an Alternative Payment Model, an eligible professional shall enter into a contract with the Administrator of the Centers for Medicare & Medicaid Services under this subsection. For purposes of this section, such an eligible professional who so participates under such an Alternative Payment Model in this section is referred to as a "participating APM provider".

(B) REQUIREMENTS.—The Secretary shall establish criteria for eligible professionals to enter into contracts under this paragraph for purposes of participation under a demonstration program with respect to an Alternative Payment Model. Such criteria shall ensure participation under such model of a sufficient number of eligible professionals for whom the model was designed in order to satisfy the criterion described in paragraph (2)(A)(iii)(II).

(4) REPORTING AND EVALUATION.—

(A) INDEPENDENT EVALUATION ENTITY.—Under this subsection, the Secretary shall enter into a contract with an independent entity to evaluate Alternative Payment Models under demonstration programs under this subsection based on appropriate measures specified under subparagraph (B). In this section, such entity shall be referred to as the "independent evaluation entity". Such contract shall be entered into in a timely manner so as to ensure evaluation of an Alternative Payment Model under a demonstration program under this subsection may begin as soon as possible after the model is approved under paragraph (2).

(B) PERFORMANCE MEASURES.—For purposes of this subsection, the Secretary shall specify—

(i) measures to evaluate Alternative Payment Models under demonstration programs under this subsection, which may include measures suggested under subsection (c) and shall be sufficient to allow for a comprehensive assessment of such a model; and

(ii) quality measures on which participating APM providers shall report, which shall be similar to measures applicable under section 1848(k).

(C) REPORTING REQUIREMENTS.—A contract entered into with a participating APM provider under paragraph (3)

shall require such provider to report on appropriate measures specified under subparagraph (B).

(D) PERIODIC REVIEW.—The independent evaluation entity shall periodically review and analyze and submit such analysis to the Secretary and the participating APM providers involved data reported under subparagraph (C) and such other data as deemed necessary to evaluate the model.

(E) FINAL EVALUATION.—Not later than 6 months after the date of completion of a demonstration program, the independent evaluation entity shall submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services (and make publicly available) a report on each model evaluated under such program. Such report shall include—

(i) outcomes on the clinical and claims data received through such program with respect to such model;

(ii) recommendations on—

(I) whether or not such model should be implemented as an eligible APM under this section; or

(II) whether or not the evaluation of such model under the demonstration program should be extended or expanded;

(iii) the justification for each such recommendation described in clause (ii); and

(iv) in the case of a recommendation to implement such model as an eligible APM, recommendations on standardized rules for purposes of such implementation.

(5) APPROVAL OF EXTENDING EVALUATION UNDER DEMONSTRATION.—Not later than 90 days after the date of receipt of a submission under paragraph (4)(E), the Secretary shall, including based on a recommendation submitted under such paragraph, determine whether an Alternative Payment Model may be extended or expanded under the demonstration program.

(6) TERMINATION.—The Secretary shall terminate a demonstration program for a model under this subsection unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies), after testing has begun, that the model is expected to—

(A) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under this title;

(B) reduce spending under this title without reducing the quality of care; or

(C) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

(7) FUNDING.—

(A) IN GENERAL.—There are appropriated, from amounts in the Federal Supplementary Medical Insurance Trust Fund under section 1841 not otherwise appropriated and as of the date of the enactment of this section, $2,000,000,000 for the purposes described in subparagraph

(B), of which no more than 2.5 percent may be used for the purpose described in clause (iii) of such subparagraph. Amounts appropriated under this subparagraph shall be available until expended.

(B) PURPOSES.—Amounts appropriated under subparagraph (A) shall be used for—

(i) payments for items and services furnished by participating APM providers under an Alternative Payment Model under a demonstration program under this subsection that—

(I) would not otherwise be eligible for payment under this title; or

(II) exceed the amount of payment that would otherwise be made for such items and services under this title if such items and services were not furnished under such demonstration program;

(ii) the evaluations provided for under this section of models under such a demonstration program;

(iii) payment to the APM contracting entity for carrying out its duties under this section; and

(iv) for otherwise carrying out this subsection.

(C) LIMITATION.—The amounts appropriated under subparagraph (A) are the only amounts authorized or appropriated to carry out the purposes described in subparagraph (B).

(f) IMPLEMENTATION OF RECOMMENDED MODELS AS ELIGIBLE APMS.—

(1) ASSESSMENT.—With respect to each Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I), the Secretary shall review the basis for such recommendation and assess and determine, in consultation with the Chief Actuary of the Centers for Medicare & Medicaid Services, whether the model is significantly likely to continue to result in meeting the criterion described in subsection (e)(2)(A)(iii)(I), with or without a modification described in paragraph (5).

(2) IMPLEMENTATION THROUGH RULEMAKING.—

(A) PUBLICATION OF NPRM.—If the Secretary determines that such a model is significantly likely to meet such criterion, the Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a notice of proposed rulemaking to implement such model, including as modified under paragraph (5).

(B) COMMENTS BY MEDPAC.—Not later than 90 days after the date of issuance of such notice with respect to a model, the Medicare Payment Advisory Commission shall submit comments on the proposed rule for such model to Congress and to the Secretary. Such comments shall include an evaluation of the reports from the contracting entity and independent evaluation entity on such model regarding the model's impact on expenditures and quality of care under this title.

(C) FINAL RULE AND CONDITIONS.—The Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a final notice implementing such proposed rule, including as modified under paragraph (5), as an eligible APM only if—

(i) the Secretary determines that such model is expected to—

(I) reduce spending under this title without reducing the quality of care; or

(II) improve the quality of patient care without increasing spending;

(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such model would reduce (or would not result in any increase in) spending under this title;

(iii) the Secretary determines that such model would not deny or limit the coverage or provision of benefits under this title for applicable individuals;

(iv) the Secretary determines that the model is significantly likely to result in the participation of a sufficient number of appropriate eligible professionals for whom the model was designed in order to satisfy the criterion described in subsection (d)(2)(A)(iii)(II);

(v) the Secretary determines that the model applies rules of coordination described in paragraph (6); and

(vi) the Secretary determines that model meets such other criteria as the Secretary may determine.

(3) APPLICABLE PHYSICIAN FEE SCHEDULE RULEMAKING PROCESS.—For purposes of paragraph (2), in the case of an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I)—

(A) on or before April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of that year of the fee schedule amounts under this section for the succeeding year; or

(B) after April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of the following year of the fee schedule amounts under this section for the second succeeding year.

(4) JUSTIFICATION FOR DISAPPROVALS.—In the case that an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I) is not implemented as an eligible APM under this subsection, the Secretary shall make publicly available the rational, in detail, for such decision.

(5) MODIFICATIONS BY SECRETARY.—For purposes of this subsection, the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I) to ensure that the model meets the requirements under paragraph (1)(B). Such a modification may include one or more of the following:

(A) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

(B) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

(C) A change to the rules of coordination described in paragraph (6).

(D) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

(E) Such other change as the Secretary may specify.

(6) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

(A) IN GENERAL.—Rules of coordination described in this paragraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

(B) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

(C) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.

(g) PERIODIC REVIEW AND TERMINATION.—

(1) PERIODIC REVIEW.—In the case of an Alternative Payment Model that has been implemented, the Secretary and the Chief Actuary of the Centers for Medicare & Medicaid Services shall review such model every 3 years to determine (and certify, in the case of the Chief Actuary and spending under this title), for the previous 3 years, whether the model has—

(A) reduced the quality of care, or

(B) increased spending under this title,

compared to the quality of care or spending that would have resulted if the model had not been implemented.

(2) TERMINATION.—

(A) QUALITY OF CARE REDUCTION TERMINATION.—If based upon such review the Secretary determines under paragraph (1)(A) that the model has reduced the quality of care, the Secretary may terminate such model.

(B) SPENDING INCREASE TERMINATION.—Unless such Chief Actuary certifies under paragraph (1)(B) that the expenditures under this title under the model do not exceed the expenditures that would otherwise have been made if the model had not been implemented for the period involved, the Secretary shall terminate such model.

(h) DISSEMINATION OF ELIGIBLE APMS.—Under this section there shall be established a process for specifying, and making publicly available a list of, all eligible APMs, which shall include at least those implemented under subsection (f) and demonstrations carried

out with respect to payments under section 1848 through authority in existence as of the day before the date of the enactment of this section. Under such process such list shall be periodically updated and, beginning with January 1, 2015, and annually thereafter, such list shall be published in the Federal Register.

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PART E—MISCELLANEOUS PROVISIONS

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PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

SEC. 1889. (a) * * *

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(h) QUALITY UPDATE INCENTIVE PROGRAM.—Under this section, information shall be disseminated to educate and assist eligible professionals (as defined in section 1848(k)(3)) about the quality update incentive program under section 1848(q) and quality measures under section 1848(k)(9) through multiple approaches, including a national dissemination strategy and outreach by medicare contractors.

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