

113TH CONGRESS  
1ST SESSION

# 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.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2013

Mr. BURGESS (for himself, Mr. PALLONE, Mr. UPTON, Mr. WAXMAN, Mr. PITTS, and Mr. DINGELL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

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.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Medicare Patient Access and Quality Improvement Act  
6 of 2013”.

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

- Sec. 1. Short title; table of contents.  
 Sec. 2. Reform of sustainable growth rate (SGR) and Medicare payment for  
 physicians' services.  
 Sec. 3. Expanding availability of Medicare data.  
 Sec. 4. Encouraging care coordination and medical homes.  
 Sec. 5. Miscellaneous.

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

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

7 (1) REPEAL OF SGR PAYMENT METHOD-  
 8 OLOGY.—Section 1848 of the Social Security Act  
 9 (42 U.S.C. 1395w–4) is amended—

10 (A) in subsection (d)—

11 (i) in paragraph (1)(A), by inserting  
 12 “or a subsequent paragraph or section  
 13 1848A” after “paragraph (4)”; and

14 (ii) in paragraph (4)—

15 (I) in the heading, by striking  
 16 “YEARS BEGINNING WITH 2001” and  
 17 inserting “2001, 2002, AND 2003”; and

18 (II) in subparagraph (A), by  
 19 striking “a year beginning with 2001”  
 20 and inserting “2001, 2002, and  
 21 2003”; and

22 (B) in subsection (f)—

1 (i) in paragraph (1)(B), by inserting  
2 “through 2013” after “of such succeeding  
3 year”; and

4 (ii) in paragraph (2), by inserting  
5 “and ending with 2013” after “beginning  
6 with 2000”.

7 (2) UPDATE OF RATES FOR 2014 THROUGH  
8 2018.—Subsection (d) of section 1848 of the Social  
9 Security Act (42 U.S.C. 1395w-4) is amended by  
10 adding at the end the following new paragraph:

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

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

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

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

22 “(16) UPDATE BEGINNING WITH 2019.—

23 “(A) IN GENERAL.—Subject to subpara-  
24 graph (B), the update to the single conversion

1 factor established in paragraph (1)(C) for each  
2 year beginning with 2019 shall be 0.5 percent.

3 “(B) ADJUSTMENT.—In the case of an eli-  
4 gible professional (as defined in subsection  
5 (k)(3)) who does not have a payment arrange-  
6 ment described in section 1848A(a) in effect,  
7 the update under subparagraph (A) for a year  
8 beginning with 2019 shall be adjusted by the  
9 applicable quality adjustment determined under  
10 subsection (q)(3) for the year involved.”; and

11 (B) in subsection (i)(1)—

12 (i) by striking “and” at the end of  
13 subparagraph (D);

14 (ii) by striking the period at the end  
15 of subparagraph (E) and inserting “,  
16 and”; and

17 (iii) by adding at the end the fol-  
18 lowing new subparagraph:

19 “(F) the implementation of subsection  
20 (q).”.

21 (2) ENHANCING PHYSICIAN QUALITY REPORT-  
22 ING SYSTEM TO SUPPORT QUALITY UPDATE INCEN-  
23 TIVE PROGRAM.—Section 1848 of the Social Secu-  
24 rity Act (42 U.S.C. 1395w-4) is amended—

1 (A) in subsection (k)(1), in the first sen-  
2 tence, by inserting “and, if applicable, clinical  
3 practice improvement activities,” after “quality  
4 measures”;

5 (B) in subsection (k)(2)—

6 (i) in subparagraph (C)—

7 (I) in the subparagraph heading,  
8 by striking “AND SUBSEQUENT  
9 YEARS” and inserting “THROUGH  
10 2018”; and

11 (II) in clause (i), by inserting  
12 “(before 2019)” after “subsequent  
13 year”;

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

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

18 “(D) FOR 2019 AND SUBSEQUENT  
19 YEARS.—For purposes of reporting data on  
20 quality measures and, as applicable clinical  
21 practice improvement activities, for covered pro-  
22 fessional services furnished during the perform-  
23 ance period (as defined in subsection (q)(2)(B))  
24 with respect to 2019 and the performance pe-  
25 riod with respect to each subsequent year, sub-

1           ject to subsection (q)(1)(D), the quality meas-  
2           ures and clinical practice improvement activities  
3           specified under this paragraph shall be, with re-  
4           spect to an eligible professional, the quality  
5           measures and, as applicable, clinical practice  
6           improvement activities within the final core  
7           measure set under paragraph (9)(F) applicable  
8           to the peer cohort of such provider and year in-  
9           volved.”; and

10                   (iv) in subparagraph (E), as redesign-  
11                   nated by subparagraph (B)(ii) of this para-  
12                   graph, by striking “AND SUBSEQUENT  
13                   YEARS”;

14           (C) in subsection (k)(3)—

15                   (i) in the paragraph heading, by strik-  
16                   ing “COVERED PROFESSIONAL SERVICES  
17                   AND ELIGIBLE PROFESSIONALS DEFINED”  
18                   and inserting “DEFINITIONS”; and

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

21                   “(C) CLINICAL PRACTICE IMPROVEMENT  
22                   ACTIVITIES.—The term ‘clinical practice im-  
23                   provement activity’ means an activity that rel-  
24                   evant eligible professional organizations and  
25                   other relevant stakeholders identify as improv-

1 ing clinical practice or care delivery and that  
2 the Secretary determines, when effectively exe-  
3 cuted, is likely to result in improved outcomes.

4 “(D) ELIGIBLE PROFESSIONAL ORGANIZA-  
5 TION.—The term ‘eligible professional organiza-  
6 tion’ means a professional organization that is  
7 recognized by the American Board of Medical  
8 Specialties, American Osteopathic Association,  
9 American Board of Physician Specialties, or an  
10 equivalent certification board.

11 “(E) PEER COHORT.—The term ‘peer co-  
12 hort’ means a peer cohort identified on the list  
13 under paragraph (9)(B), as updated under  
14 clause (ii) of such paragraph.”;

15 (D) in subsection (k)(7), by striking “ and  
16 the application of paragraphs (4) and (5)” and  
17 inserting “, the application of paragraphs (4)  
18 and (5), and the implementation of paragraph  
19 (9)”;

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

22 “(9) ESTABLISHMENT OF FINAL CORE MEAS-  
23 URE SETS.—

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

1           “(i) for each peer cohort identified  
2           under subparagraph (B) and in accordance  
3           with this paragraph, there shall be pub-  
4           lished a final core measure set under sub-  
5           paragraph (F), which shall consist of qual-  
6           ity measures and may also consist of clin-  
7           ical practice improvement activities, with  
8           respect to which eligible professionals shall,  
9           subject to subsection (m)(3)(C), be as-  
10          sessed for purposes of determining, for  
11          years beginning with 2019, the quality ad-  
12          justment under subsection (q)(3) applica-  
13          ble to such professionals; and

14          “(ii) each eligible professional shall  
15          self-identify, in accordance with subpara-  
16          graph (B), within such a peer cohort for  
17          purposes of such assessments.

18          “(B) PEER COHORTS.—The Secretary  
19          shall identify (and publish a list of) peer co-  
20          horts by which eligible professionals shall self-  
21          identify for purposes of this subsection and sub-  
22          section (q) with respect to a performance period  
23          (as defined in subsection (q)(2)(B)) for a year  
24          beginning with 2019. For purposes of this sub-  
25          section and subsection (q), the Secretary shall



1 develop one or more peer cohorts for multispe-  
2 cialty groups, each of which shall be included as  
3 a peer cohort under this subparagraph. Such  
4 self-identification will be made through such a  
5 process and at such time as specified under the  
6 system under this subsection. Such list—

7 “(i) shall include, as peer cohorts,  
8 provider specialties defined by the Amer-  
9 ican Board of Medical Specialties or equiv-  
10 alent certification boards and such other  
11 cohorts as established under this section in  
12 order to capture classifications of providers  
13 across eligible professional organizations  
14 and other practice areas, groupings, or cat-  
15 egories; and

16 “(ii) shall be updated from time to  
17 time.

18 “(C) QUALITY MEASURES FOR CORE MEAS-  
19 URE SETS.—

20 “(i) DEVELOPMENT.—Under the sys-  
21 tem under this subsection there shall be es-  
22 tablished a process for the development of  
23 quality measures under this subparagraph  
24 for purposes of potential inclusion of such

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

3 “(I) there shall be coordination,  
4 to the extent possible, across organi-  
5 zations developing such measures;

6 “(II) eligible professional organi-  
7 zations and other relevant stake-  
8 holders may submit best practices and  
9 clinical practice guidelines for the de-  
10 velopment of quality measures that  
11 address quality domains (as defined  
12 under clause (ii)) for potential inclu-  
13 sion in such core measure sets;

14 “(III) there is encouraged to be  
15 developed, as appropriate, meaningful  
16 outcome measures (or quality of life  
17 measures in cases for which outcomes  
18 may not be a valid measurement),  
19 functional status measures, and pa-  
20 tient experience measures; and

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

1           “(ii) QUALITY DOMAINS.—For pur-  
2           poses of this paragraph, the term ‘quality  
3           domains’ means at least the following do-  
4           mains:

5                     “(I) Clinical care.

6                     “(II) Safety.

7                     “(III) Care coordination.

8                     “(IV) Patient and caregiver expe-  
9           rience.

10                    “(V) Population health and pre-  
11           vention.

12                   “(D) PROCESS FOR ESTABLISHING CORE  
13           MEASURE SETS.—

14                   “(i) IN GENERAL.—Under the system  
15           under this subsection, for purposes of sub-  
16           paragraph (A), there shall be established a  
17           process to approve final core measure sets  
18           under this paragraph for peer cohorts.  
19           Each such final core measure set shall be  
20           composed of quality measures (and, as ap-  
21           plicable, clinical practice improvement ac-  
22           tivities) with respect to which eligible pro-  
23           fessionals within such peer cohort shall re-  
24           port under this subsection and be assessed

1 under subsection (q). Such process shall  
2 provide—

3 “(I) for the establishment of cri-  
4 teria, which shall be made publicly  
5 available before the request is made  
6 under clause (ii), for selecting such  
7 measures and activities for potential  
8 inclusion in such a final core measure  
9 set; and

10 “(II) that all peer cohorts, and to  
11 the extent practicable all quality do-  
12 mains, are addressed by measures  
13 and, as applicable, clinical practice  
14 improvement activities selected to be  
15 included in a core measure set under  
16 this paragraph, which may include  
17 through the use of such a measure or  
18 clinical practice improvement activity  
19 that addresses more than one such  
20 domain or cohort.

21 “(ii) SOLICITATION OF PUBLIC INPUT  
22 ON QUALITY MEASURES AND CLINICAL  
23 PRACTICE IMPROVEMENT ACTIVITIES.—  
24 Under the process established under clause  
25 (i), relevant eligible professional organiza-

1 tions and other relevant stakeholders shall  
2 be requested to identify and submit quality  
3 measures and clinical practice improve-  
4 ment activities (as defined in paragraph  
5 (3)(C)) for selection under this paragraph.  
6 For purposes of the previous sentence,  
7 measures and activities may be submitted  
8 regardless of whether such measures were  
9 previously published in a proposed rule or  
10 endorsed by an entity with a contract  
11 under section 1890(a).

12 “(E) CORE MEASURE SETS.—

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

16 “(I) shall select, from quality  
17 measures described in clause (ii) ap-  
18 plicable to a peer cohort, quality  
19 measures to be included in a core  
20 measure set for such cohort;

21 “(II) shall, to the extent there  
22 are insufficient quality measures ap-  
23 plicable to a peer cohort to address  
24 one or more applicable quality do-  
25 mains, select to be included in a core

1 measure set for such cohort such clin-  
2 ical practice improvement activities  
3 described in clause (ii)(IV) as are  
4 needed and available to sufficiently  
5 address such an applicable domain  
6 with respect to such peer cohort; and

7 “(III) may select, to the extent  
8 determined appropriate, any addi-  
9 tional clinical practice improvement  
10 activities described in clause (ii)(IV)  
11 applicable to a peer cohort to be in-  
12 cluded in a core measure set for such  
13 cohort.

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

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

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

3 “(II) a measure developed under  
4 paragraph (2)(C) or a measure other-  
5 wise applied or developed for a similar  
6 purpose under this section;

7 “(III) a measure developed under  
8 subparagraph (C); or

9 “(IV) a measure or activity sub-  
10 mitted under subparagraph (D)(ii).

11 A measure or activity may be selected  
12 under this subparagraph, regardless of  
13 whether such measure or activity was pre-  
14 viously published in a proposed rule. A  
15 measure so selected shall be evidence-based  
16 but (other than a measure described in  
17 subclause (I)) shall not be required to be  
18 consensus-based.

19 “(iii) TRANSPARENCY.—Before pub-  
20 lishing in a final regulation a core measure  
21 set under clause (i) as a final core measure  
22 set under subparagraph (F), the Secretary  
23 shall—

24 “(I) submit for publication in ap-  
25 plicable specialty-appropriate peer-re-

1 viewed journals such core measure set  
2 under clause (i) and the method for  
3 developing and selecting measures  
4 within such set, including clinical and  
5 other data supporting such measures,  
6 and, as applicable, the method for se-  
7 lecting clinical practice improvement  
8 activities included within such set;  
9 and

10 “(II) regardless of whether or not  
11 the core measure set or method is  
12 published in such a journal under sub-  
13 clause (I), provide for notice of the  
14 proposed regulation in the Federal  
15 Register, including with respect to the  
16 applicable methods and data described  
17 in subclause (I), and a period for pub-  
18 lic comment thereon.

19 “(F) FINAL CORE MEASURE SETS.—Not  
20 later than November 15 of the year prior to the  
21 first day of a performance period, the Secretary  
22 shall publish a final regulation in the Federal  
23 Register that includes a final core measure set  
24 (and the applicable methods and data described



1 in subparagraph (E)(iii)(I)) for each peer co-  
2 hort to be applied for such performance period.

3 “(G) PERIODIC REVIEW AND UPDATES.—

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

8 “(I) the quality measures and  
9 clinical practice improvement activities  
10 selected for inclusion in final core  
11 measure sets under this paragraph for  
12 each year such measures and activi-  
13 ties are to be applied under this sub-  
14 section or subsection (q) to ensure  
15 that such measures and activities con-  
16 tinue to meet the conditions applicable  
17 to such measures and activities for  
18 such selection; and

19 “(II) the final core measure sets  
20 published under subparagraph (F) for  
21 each year such sets are to be applied  
22 to peer cohorts of eligible profes-  
23 sionals to ensure that each applicable  
24 set continues to meet the conditions

1 applicable to such sets before being so  
2 published.

3 “(ii) COLLABORATION WITH STAKE-  
4 HOLDERS.—In carrying out clause (i), rel-  
5 evant eligible professional organizations  
6 and other relevant stakeholders may iden-  
7 tify and submit updates to quality meas-  
8 ures and clinical practice improvement ac-  
9 tivities selected under this paragraph for  
10 inclusion in final core measure sets as well  
11 as any additional quality measures and  
12 clinical practice improvement activities.  
13 Not later than November 15 of the year  
14 prior to the first day of a performance pe-  
15 riod, submissions under this clause shall be  
16 reviewed.

17 “(iii) ADDITIONAL, AND UPDATES TO,  
18 MEASURES AND ACTIVITIES.—Based on  
19 the review conducted under this subpara-  
20 graph for a period, as needed, there shall  
21 be—

22 “(I) selected additional, and up-  
23 dates to, quality measures and clinical  
24 practice improvement activities se-  
25 lected under this paragraph for poten-

1           tial inclusion in final core measure  
2           sets in the same manner such quality  
3           measures and clinical practice im-  
4           provement activities are selected  
5           under this paragraph for such poten-  
6           tial inclusion;

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

11                   “(III) updated final core measure  
12          sets published under subparagraph  
13          (F) in the same manner as such sets  
14          are approved under such subpara-  
15          graph.

16          For purposes of this subsection and sub-  
17          section (q), a final core measure set, as up-  
18          dated under this subparagraph, shall be  
19          treated in the same manner as a final core  
20          measure set published under subparagraph  
21          (F).

22                   “(iv) TRANSPARENCY.—

23                   “(I) NOTIFICATION REQUIRED  
24          FOR CERTAIN UPDATES.—In the case  
25          of an update under subclause (II) or

1 (III) of clause (iii) that adds, materi-  
2 ally changes, or removes a measure or  
3 activity from a measure set, such up-  
4 date shall not apply under this sub-  
5 section or subsection (q) unless notifi-  
6 cation of such update is made avail-  
7 able to applicable eligible profes-  
8 sionals.

9 “(II) PUBLIC AVAILABILITY OF  
10 UPDATED FINAL CORE MEASURE  
11 SETS.—Subparagraph (E)(iii) shall  
12 apply with respect to measure sets up-  
13 dated under subclause (II) or (III) of  
14 clause (iii) in the same manner as  
15 such subparagraph applies to applica-  
16 ble core measure sets under subpara-  
17 graph (E).

18 “(H) COORDINATION WITH EXISTING PRO-  
19 GRAMS.—The development and selection of  
20 quality measures and clinical practice improve-  
21 ment activities under this paragraph shall, as  
22 appropriate, be coordinated with the develop-  
23 ment and selection of existing measures and re-  
24 quirements, such as the development of the  
25 Physician Compare Website under subsection

1 (m)(5)(G) and the application of resource use  
2 management under subsection (n). To the ex-  
3 tent feasible, such measures and activities shall  
4 align with measures used by other payers and  
5 with measures and activities in use under other  
6 programs in order to streamline the process of  
7 such development and selection under this para-  
8 graph. The Secretary shall develop a plan to in-  
9 tegrate reporting on quality measures under  
10 this subsection with reporting requirements  
11 under subsection (o) relating to the meaningful  
12 use of certified EHR technology.

13 “(I) CONSULTATION WITH RELEVANT ELI-  
14 GIBLE PROFESSIONAL ORGANIZATIONS AND  
15 OTHER RELEVANT STAKEHOLDERS.—Relevant  
16 eligible professional organizations (as defined in  
17 paragraph (3)(D)) and other relevant stake-  
18 holders, including State and national medical  
19 societies, shall be consulted in carrying out this  
20 paragraph.

21 “(J) OPTIONAL APPLICATION.—The proc-  
22 ess under section 1890A is not required to  
23 apply to the development or selection of meas-  
24 ures under this paragraph.”; and

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

10 (3) ESTABLISHMENT OF QUALITY UPDATE IN-  
11 CENTIVE PROGRAM.—

12 (A) IN GENERAL.—Section 1848 of the So-  
13 cial Security Act (42 U.S.C. 1395w-4) is  
14 amended by adding at the end the following  
15 new subsection:

16 “(q) QUALITY UPDATE INCENTIVE PROGRAM.—

17 “(1) ESTABLISHMENT.—

18 “(A) IN GENERAL.—The Secretary shall  
19 establish an eligible professional quality update  
20 incentive program (in this section referred to as  
21 the ‘quality update incentive program’) under  
22 which—

23 “(i) there is developed and applied, in  
24 accordance with paragraph (2), appro-  
25 priate methodologies for assessing the per-

1 performance of eligible professionals with re-  
2 spect to quality measures and clinical prac-  
3 tice improvement activities included within  
4 the final core measure sets published under  
5 subsection (k)(9)(F) applicable to the peer  
6 cohorts of such providers;

7 “(ii) there is applied, consistent with  
8 the system under subsection (k), methods  
9 for collecting information needed for such  
10 assessments (which shall involve the min-  
11 imum amount of administrative burden re-  
12 quired to ensure reliable results); and

13 “(iii) the applicable update adjust-  
14 ments under paragraph (3) are determined  
15 by such assessments.

16 “(B) DEFINITIONS.—

17 “(i) ELIGIBLE PROFESSIONAL.—In  
18 this subsection, the term ‘eligible profes-  
19 sional’ has the meaning given such term in  
20 subsection (k)(3), except that such term  
21 shall not include a professional who has a  
22 payment arrangement described in section  
23 1848A(a)(1) in effect.

24 “(ii) PEER COHORTS; CLINICAL PRAC-  
25 TICE IMPROVEMENT ACTIVITIES; ELIGIBLE

1           PROFESSIONAL ORGANIZATIONS.—In this  
2           subsection, the terms ‘peer cohort’, ‘clinical  
3           practice improvement activity’, and ‘eligible  
4           professional organization’ have the mean-  
5           ings given such terms in subsection (k)(3).

6           “(C) CONSULTATION WITH ELIGIBLE PRO-  
7           FESSIONAL ORGANIZATIONS AND OTHER REL-  
8           EVANT STAKEHOLDERS.—Eligible professional  
9           organizations and other relevant stakeholders,  
10          including State and national medical societies,  
11          shall be consulted in carrying out this sub-  
12          section.

13          “(D) APPLICATION AT GROUP PRACTICE  
14          LEVEL.—The Secretary shall establish a proc-  
15          ess, consistent with subsection (m)(3)(C), under  
16          which the provisions of this subsection are ap-  
17          plied to eligible professionals in a group prac-  
18          tice if the group practice reports measures de-  
19          termined appropriate by the Secretary under  
20          such subsection.

21          “(E) COORDINATION WITH EXISTING PRO-  
22          GRAMS.—The application of measures and clin-  
23          ical practice improvement activities and assess-  
24          ment of performance under this subsection  
25          shall, as appropriate, be coordinated with the



1 application of measures and assessment of per-  
2 formance under other provisions of this section.

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

6 “(A) ESTABLISHMENT OF METHODS FOR  
7 ASSESSMENT.—

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

11 “(I) establish one or more meth-  
12 ods, applicable with respect to a per-  
13 formance period, to assess (using a  
14 scoring scale of 0 to 100) the per-  
15 formance of an eligible professional  
16 with respect to, subject to paragraph  
17 (1)(D), quality measures and clinical  
18 practice improvement activities in-  
19 cluded within the final core measure  
20 set published under subsection  
21 (k)(9)(F) applicable for the period to  
22 the peer cohort in which the provider  
23 self-identified under subsection  
24 (k)(9)(B) for such period; and

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

7                   “(ii) METHODS.—Such methods shall,  
8                   with respect to an eligible professional,  
9                   provide that the performance of such pro-  
10                  fessional shall, subject to paragraph  
11                  (1)(D), be assessed for a performance pe-  
12                  riod with respect to the quality measures  
13                  and clinical practice improvement activities  
14                  within the final core measure set for such  
15                  period for the peer cohort of such profes-  
16                  sional and on which information is col-  
17                  lected from such professional.

18                  “(iii) WEIGHTING OF MEASURES.—  
19                  Such a method may provide for the assign-  
20                  ment of different scoring weights or, as ap-  
21                  propriate, other factors—

22                         “(I) for quality measures and  
23                         clinical practice improvement activi-  
24                         ties;

1                   “(II) based on the type or cat-  
2                   egory of measure or activity; and

3                   “(III) based on the extent to  
4                   which a quality measure or clinical  
5                   practice improvement activity mean-  
6                   ingfully assesses quality.

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

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

17                  “(B) PERFORMANCE PERIOD.—There shall  
18                  be established a period (in this subsection re-  
19                  ferred to as a ‘performance period’), with re-  
20                  spect to a year (beginning with 2019) for which  
21                  the quality adjustment is applied under para-  
22                  graph (3), to assess performance on quality  
23                  measures and clinical practice improvement ac-  
24                  tivities. Each such performance period shall be  
25                  a period of 12 consecutive months and shall end

1 as close as possible to the beginning of the year  
2 for which such adjustment is applied.

3 “(3) QUALITY ADJUSTMENT TAKING INTO AC-  
4 COUNT QUALITY ASSESSMENTS.—

5 “(A) QUALITY ADJUSTMENT.—For pur-  
6 poses of subsection (d)(16), if the composite  
7 score computed under paragraph (2)(A) for an  
8 eligible professional for a year (beginning with  
9 2019) is—

10 “(i) a score of 67 or higher, the qual-  
11 ity adjustment under this paragraph for  
12 the eligible professional and year is 1 per-  
13 centage point;

14 “(ii) a score of at least 34, but below  
15 67, the quality adjustment under this  
16 paragraph for the eligible professional and  
17 year is zero; or

18 “(iii) a score below 34, the quality ad-  
19 justment under this paragraph for the eli-  
20 gible professional and year is  $-1$  percent-  
21 age point.

22 “(B) NO EFFECT ON SUBSEQUENT YEARS’  
23 QUALITY ADJUSTMENTS.—Each such quality  
24 adjustment shall be made each year without re-

1           gard to the update adjustment for a previous  
2           year under this paragraph.

3           “(4) TRANSITION FOR NEW ELIGIBLE PROFES-  
4           SIONALS.—In the case of a physician, practitioner,  
5           or other supplier that during a performance period,  
6           with respect to a year for which a quality adjust-  
7           ment is applied under paragraph (3), first becomes  
8           an eligible professional (and had not previously sub-  
9           mitted claims under this title as a person, as an en-  
10          tity, or as part of a physician group or under a dif-  
11          ferent billing number or tax identifier), the quality  
12          adjustment under this subsection applicable to such  
13          physician, practitioner, or supplier—

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

16                 “(B) for a year, with respect to a subse-  
17                 quent performance period, shall be the quality  
18                 adjustment that would otherwise be applied  
19                 under this subsection.

20           “(5) FEEDBACK.—

21                 “(A) FEEDBACK.—

22                         “(i) ONGOING FEEDBACK.—Under the  
23                         process under subsection (m)(5)(H), there  
24                         shall be provided, as real time as possible,

1 but at least quarterly, to each eligible pro-  
2 fessional feedback—

3 “(I) on the performance of such  
4 provider with respect to quality meas-  
5 ures and clinical practice improvement  
6 activities within the final core meas-  
7 ure set published under subsection  
8 (k)(9)(F) for the applicable perform-  
9 ance period and the peer cohort of  
10 such professional; and

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

15 “(ii) USE OF REGISTRIES AND OTHER  
16 MECHANISMS.—Feedback under this sub-  
17 paragraph shall, to the extent an eligible  
18 professional chooses to participate in a  
19 data registry for purposes of this sub-  
20 section (including registries under sub-  
21 sections (k) and (m)), be provided and  
22 based on performance received through the  
23 use of such registry, and to the extent that  
24 an eligible professional chooses not to par-  
25 ticipate in such a registry for such pur-

1           poses, be provided through other similar  
2           mechanisms that allow for the provision of  
3           such feedback and receipt of such perform-  
4           ance information.

5           “(B) DATA MECHANISM.—Under the qual-  
6           ity update incentive program, there shall be de-  
7           veloped an electronic interactive eligible profes-  
8           sional mechanism through which such a profes-  
9           sional may receive performance data, including  
10          data with respect to performance on the meas-  
11          ures and activities developed and selected under  
12          this section. Such mechanism shall be developed  
13          in consultation with private payers and health  
14          insurance issuers (as defined in section  
15          2791(b)(2) of the Public Health Service Act) as  
16          appropriate.

17          “(C) TRANSFER OF FUNDS.—The Sec-  
18          retary shall provide for the transfer of  
19          \$100,000,000 from the Federal Supplementary  
20          Medical Insurance Trust Fund established in  
21          section 1841 to the Center for Medicare & Med-  
22          icaid Services Program Management Account to  
23          support such efforts to develop the infrastruc-  
24          ture as necessary to carry out subsection (k)(9)  
25          and this subsection and for purposes of section

1 1889(h). Such funds shall be so transferred on  
2 the date of the enactment of this subsection  
3 and shall remain available until expended.”.

4 (B) INCENTIVE TO REPORT UNDER QUALITY  
5 UPDATE INCENTIVE PROGRAM.—Section  
6 1848(a)(8)(A) of the Social Security Act (42  
7 U.S.C. 1395w-4(a)(8)(A)) is amended—

8 (i) in clause (i), by striking “With re-  
9 spect to” and inserting “Subject to clause  
10 (iii), with respect to”; and

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

13 “(iii) APPLICATION TO ELIGIBLE PRO-  
14 FESSIONALS NOT REPORTING.—With re-  
15 spect to covered professional services (as  
16 defined in subsection (k)(3)) furnished by  
17 an eligible professional during 2019 or any  
18 subsequent year, if the eligible professional  
19 does not submit data for the performance  
20 period (as defined in subsection (q)(2)(B))  
21 with respect to such year on, subject to  
22 subsection (q)(1)(D), the quality measures  
23 and, as applicable, clinical practice im-  
24 provement activities within the final core  
25 measure set under subsection (k)(9)(F) ap-



1           plicable to the peer cohort of such pro-  
2           vider, the fee schedule amount for such  
3           services furnished by such professional  
4           during the year (including the fee schedule  
5           amount for purposes of determining a pay-  
6           ment based on such amount) shall be equal  
7           to 95 percent (in lieu of the applicable per-  
8           cent) of the fee schedule amount that  
9           would otherwise apply to such services  
10          under this subsection (determined after ap-  
11          plication of paragraphs (3), (5), and (7),  
12          but without regard to this paragraph). The  
13          Secretary shall develop a minimum per  
14          year caseload threshold, with respect to eli-  
15          gible professionals, and the previous sen-  
16          tence shall not apply to eligible profes-  
17          sionals with a caseload for a year below  
18          such threshold for such year.”.

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

23           “(h) QUALITY UPDATE INCENTIVE PROGRAM.—  
24           Under this section, information shall be disseminated to  
25           educate and assist eligible professionals (as defined in sec-

1 tion 1848(k)(3)) about the quality update incentive pro-  
2 gram under section 1848(q) and quality measures under  
3 section 1848(k)(9) through multiple approaches, including  
4 a national dissemination strategy and outreach by medi-  
5 care contractors.”.

6 (4) CONFORMING AMENDMENTS.—

7 (A) TREATMENT OF SATISFACTORILY RE-  
8 PORTING PQRS MEASURES THROUGH PARTICI-  
9 PATION IN A QUALIFIED CLINICAL DATA REG-  
10 ISTRY.—Section 1848(m)(3)(D) of the Social  
11 Security Act (42 U.S.C. 1395w-4(m)(3)(D)) is  
12 amended by striking “For 2014 and subsequent  
13 years” and inserting “For each of 2014  
14 through 2018”.

15 (B) COORDINATING ENHANCED PQRS RE-  
16 PORTING WITH EHR.—Section  
17 1848(o)(2)(B)(iii) of the Social Security Act  
18 (42 U.S.C. 1395w-4(o)(2)(B)(iii)) is amended  
19 by striking “subsection (k)(2)(C)” and inserting  
20 “subparagraph (C) or (D) of subsection  
21 (k)(2)”.

22 (C) COORDINATING PQRS REPORTING PE-  
23 RIOD WITH QUALITY UPDATE INCENTIVE PRO-  
24 GRAM PERFORMANCE PERIOD.—Section

1 1848(m)(6)(C) of the Social Security Act (42  
2 U.S.C. 1395w-4(m)(6)(C)) is amended—

3 (i) in clause (i), by striking “and (iii)”  
4 and inserting “, (iii), and (iv)”; and

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

7 “(iv) COORDINATION WITH QUALITY  
8 UPDATE INCENTIVE PROGRAM.—For 2019  
9 and each subsequent year the reporting pe-  
10 riod shall be coordinated with the perform-  
11 ance period under subsection (q)(2)(B).”.

12 (D) COORDINATING EHR REPORTING WITH  
13 QUALITY UPDATE INCENTIVE PROGRAM PER-  
14 FORMANCE PERIOD.—Section 1848(o)(5)(B) of  
15 the Social Security Act (42 U.S.C. 1395w-  
16 4(o)(5)(B)) is amended by adding at the end  
17 the following: “Beginning for 2019, the EHR  
18 reporting period shall be coordinated with the  
19 performance period under subsection  
20 (q)(2)(B).”.

21 (c) ADVANCING ALTERNATIVE PAYMENT MODELS.—

22 (1) IN GENERAL.—Part B of title XVIII of the  
23 Social Security Act (42 U.S.C. 1395w-4 et seq.) is  
24 amended by adding at the end the following new sec-  
25 tion:

1 **“SEC. 1848A. ADVANCING ALTERNATIVE PAYMENT MODELS.**

2       “(a) PAYMENT MODEL CHOICE PROGRAM.—Pay-  
3 ment for covered professional services (as defined in sec-  
4 tion 1848(k)) that are furnished by an eligible professional  
5 (as defined in such section) under an Alternative Payment  
6 Model specified on the list under subsection (h) (in this  
7 section referred to as an ‘eligible APM’) shall be made  
8 under this title in accordance with the payment arrange-  
9 ment under such model. In applying the previous sentence,  
10 such a professional with such a payment arrangement in  
11 effect, shall be deemed for purposes of section 1848(a)(8)  
12 to be satisfactorily submitting data on quality measures  
13 for such covered professional services.

14       “(b) PROCESS FOR IMPLEMENTING ELIGIBLE  
15 APMS.—

16               “(1) IN GENERAL.—For purposes of subsection  
17 (a) and in accordance with this section, the Sec-  
18 retary shall establish a process under which—

19                       “(A) a contract is entered into, in accord-  
20                       ance with paragraph (2);

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

24                       “(C) Alternative Payment Models so pro-  
25                       posed are recommended, in accordance with  
26                       subsection (d), for evaluation, including through

1 the demonstration program under subsection  
2 (e), and approval under subsection (f);

3 “(D) applicable Alternative Payment Mod-  
4 els are evaluated under such demonstration pro-  
5 gram;

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

8 “(F) a comprehensive list of all eligible  
9 APMs is made publicly available, in accordance  
10 with subsection (h), for application under sub-  
11 section (a).

12 “(2) CONTRACT WITH APM CONTRACTING ENTI-  
13 TY.—

14 “(A) IN GENERAL.—For purposes of para-  
15 graph (1)(A), the Secretary shall identify and  
16 have in effect a contract with an independent  
17 entity that has appropriate expertise to carry  
18 out the functions applicable to such entity  
19 under this section. Such entity shall be referred  
20 to in this section as the ‘APM contracting enti-  
21 ty’.

22 “(B) TIMING FOR FIRST CONTRACT.—As  
23 soon as practicable, but not later than one year  
24 after the date of the enactment of this section,

1           the Secretary shall enter into the first contract  
2           under subparagraph (A).

3           “(C) COMPETITIVE PROCEDURES.—Com-  
4           petitive procedures (as defined in section 4(5)  
5           of the Office of Federal Procurement Policy Act  
6           (41 U.S.C. 403(5))) shall be used to enter into  
7           a contract under subparagraph (A).

8           “(c) SUBMISSION OF PROPOSED ALTERNATIVE PAY-  
9           MENT MODELS.—Beginning not later than 90 days after  
10          the date the Secretary enters into a contract under sub-  
11          section (b)(2) with the APM contracting entity, physi-  
12          cians, eligible professional organizations, health care pro-  
13          vider organizations, and other entities may submit to the  
14          APM contracting entity proposals for Alternative Payment  
15          Models for application under this section. Such a proposal  
16          of a model shall include suggestions for measures to be  
17          used under subsection (e)(1)(B) for purposes of evaluating  
18          such model. In reviewing submissions under this sub-  
19          section for purposes of making recommendations under  
20          subsection (d)(1), the contracting entity shall focus on  
21          submissions for such models that are intended to improve  
22          care coordination and quality for patients through modi-  
23          fying the manner in which physicians and other providers  
24          are paid under this title.

1       “(d) RECOMMENDATION BY APM CONTRACTING EN-  
2 TITY OF PROPOSED MODELS.—

3               “(1) RECOMMENDATION.—

4                       “(A) IN GENERAL.—Under the process  
5 under subsection (b), the APM contracting enti-  
6 ty shall at least annually recommend to the  
7 Secretary—

8                               “(i) based on the criteria described in  
9 subparagraph (B), Alternative Payment  
10 Models submitted under subsection (c) to  
11 be evaluated through a demonstration pro-  
12 gram under subsection (e); and

13                               “(ii) based on the criteria described in  
14 subparagraph (C), Alternative Payment  
15 Models submitted under subsection (c) for  
16 purposes of implementation under sub-  
17 section (f), without evaluation through  
18 such a demonstration program.

19       Such a recommendation may be made with re-  
20 spect to a model for which a waiver would be  
21 required under paragraph (2).

22               “(B) CRITERIA FOR RECOMMENDING MOD-  
23 ELS FOR DEMONSTRATION.—The APM con-  
24 tracting entity shall make a recommendation  
25 under subparagraph (A)(i), with respect to an

1 Alternative Payment Model, only if the entity  
2 determines that the model satisfies each of the  
3 following criteria:

4 “(i) The model has been supported by  
5 meaningful clinical and non-clinical data,  
6 with respect to a sufficient population sam-  
7 ple, that indicates the model would be suc-  
8 cessful at addressing each of the abilities  
9 described in clause (v).

10 “(ii)(I) In the case of a model that  
11 has already been evaluated and supported  
12 by data with respect to a population of in-  
13 dividuals enrolled under this part, if the  
14 model were evaluated under the dem-  
15 onstration under subsection (e) such a  
16 population would represent a sufficient  
17 number of individuals enrolled under this  
18 part to ensure meaningful evaluation.

19 “(II) In the case of a model that has  
20 not been so evaluated and supported by  
21 data with respect to such a population, the  
22 population that would be furnished services  
23 under such model if the model were evalu-  
24 ated under the demonstration under sub-  
25 section (e) would represent a sufficient



1 number of individuals enrolled under this  
2 part to ensure meaningful evaluation.

3 “(iii) Such model, including if evalu-  
4 ated under the demonstration under sub-  
5 section (e), would not deny or limit the  
6 coverage or provision of benefits under this  
7 title for applicable individuals.

8 “(iv) The implementation of such  
9 model as an eligible APM under this sec-  
10 tion is expected—

11 “(I) to reduce spending under  
12 this title without reducing the quality  
13 of care; or

14 “(II) improve the quality of pa-  
15 tient care without increasing spend-  
16 ing.

17 “(v) The proposal for such model  
18 demonstrates—

19 “(I) the potential to successfully  
20 manage the cost of furnishing items  
21 and services under this title so as to  
22 not result in expenditures under this  
23 title for individuals participating  
24 under such APM being greater than  
25 expenditures under this title for such

1 individuals if the APM were not im-  
2 plemented;

3 “(II) the ability to maintain or  
4 improve the overall patient care; and

5 “(III) the ability to maintain or  
6 improve the quality of care provided  
7 to individuals enrolled under this part  
8 who participate under such mode.

9 “(vi) The model provides for a pay-  
10 ment arrangement—

11 “(I) covering at least items and  
12 services furnished under this part by  
13 eligible professionals participating in  
14 the model;

15 “(II) in the case such payment  
16 arrangement does not provide for pay-  
17 ment under the fee schedule under  
18 section 1848 for such items and serv-  
19 ices furnished by such eligible profes-  
20 sionals, that provides for a payment  
21 adjustment based on meaningful EHR  
22 use comparable to such adjustment  
23 that would otherwise apply under sec-  
24 tion 1848; and

1                   “(III) that provides for a pay-  
2                   ment adjustment based on quality  
3                   measures comparable to such adjust-  
4                   ment that would otherwise apply  
5                   under section 1848.

6                   “(C) CRITERIA FOR RECOMMENDING MOD-  
7                   ELS FOR APPROVAL WITHOUT EVALUATION  
8                   UNDER DEMONSTRATION.—The APM con-  
9                   tracting entity may make a recommendation  
10                  under subparagraph (A)(ii), with respect to an  
11                  Alternative Payment Model, only if the entity  
12                  determines that the model has already been  
13                  evaluated for a sufficient enough period and  
14                  through such evaluation the model was shown—

15                   “(i) to have satisfied the criteria de-  
16                   scribed in each of clauses (i), (ii), (iii), and  
17                   (vi) of subparagraph (B);

18                   “(ii) to demonstrate each of the abili-  
19                   ties described in clause (v) of such sub-  
20                   paragraph; and

21                   “(iii)(I) to reduce spending under this  
22                   title without reducing the quality of care;  
23                   or

24                   “(II) improve the quality of patient  
25                   care without increasing spending.

1                   “(D) TRANSPARENCY AND DISCLO-  
2                   SURES.—

3                   “(i) DISCLOSURES.—Not later than  
4                   90 days after receipt of a submission of a  
5                   model under subsection (c) by an entity,  
6                   the APM contracting entity shall submit to  
7                   the Secretary and such entity and make  
8                   publicly available a notification on whether  
9                   or not, and if so how, the model meets cri-  
10                  teria for recommending such model under  
11                  subparagraph (A), including whether or  
12                  not such model requires a waiver under  
13                  paragraph (2). In the case that the APM  
14                  contracting entity determines not to rec-  
15                  ommend such model under this paragraph,  
16                  such notification shall include an expla-  
17                  nation of the reasons for not making such  
18                  a recommendation. Any information made  
19                  publicly available pursuant to the previous  
20                  sentence shall not include proprietary data.

21                  “(ii) SUBMISSION OF RECOMMENDED  
22                  MODELS.—The APM contracting entity  
23                  shall at least quarterly submit to the Sec-  
24                  retary, the Medicare Payment Advisory  
25                  Commission, and the Chief Actuary of the

1 Centers for Medicare & Medicaid Services  
2 the following:

3 “(I) The models recommended  
4 under subparagraph (A)(i), including  
5 any such models that require a waiver  
6 under paragraph (2), and the data  
7 and analyses on such recommended  
8 models that support the criteria de-  
9 scribed in subparagraph (B).

10 “(II) The models recommended  
11 under subparagraph (A)(ii), including  
12 any such models that require a waiver  
13 under paragraph (2), and the data  
14 and analyses on such recommended  
15 models that support the criteria de-  
16 scribed in subparagraph (C).

17 For any year beginning with 2015 that the  
18 APM contracting does not recommend any  
19 models under subparagraph (A), the entity  
20 shall instead satisfy this clause by submit-  
21 ting to the Secretary and making publicly  
22 available an explanation for not having any  
23 such recommendations.

24 “(2) MODELS REQUIRING WAIVER APPROVAL.—

1           “(A) IN GENERAL.—In the case that an  
2           Alternative Payment Model recommended under  
3           paragraph (1)(A)(i) would require a waiver  
4           from any requirement under this title, in deter-  
5           mining approval of such model, the Secretary  
6           may make such a waiver in order for such  
7           model to be evaluated under the demonstration  
8           program (if described in clause (i) of such para-  
9           graph).

10           “(B) APPROVAL.—Not later than 90 days  
11           after the date of the receipt of such submission  
12           for a model, the Secretary shall notify the APM  
13           contracting entity and the entity submitting  
14           such model under subsection (c) whether or not  
15           such a waiver for such model is provided and  
16           the reason for any denial of such a waiver.

17           “(e) DEMONSTRATION.—

18           “(1) IN GENERAL.—Subject to paragraphs (5),  
19           (6), and (7), the Secretary may conduct a dem-  
20           onstration program, with respect to an Alternative  
21           Payment Model approved under paragraph (2),  
22           under which participating entities shall be paid  
23           under this title in accordance with the payment ar-  
24           rangement under such model and such model shall  
25           be evaluated by the independent evaluation entity

1 under paragraph (3). The duration of a demonstra-  
2 tion program under this subsection, with respect to  
3 such a model, shall be 3 years (or a shorter period,  
4 taking into account the applicable recommendation  
5 under subsection (d)(1)(A)(i)).

6 “(2) APPROVAL BY SECRETARY OF MODELS  
7 FOR DEMONSTRATION.—Not later than 90 days  
8 after the date of receipt of a recommendation under  
9 subsection (d)(1)(A)(i), with respect to an Alter-  
10 native Payment Model, the Secretary shall approve  
11 such model for a demonstration program under this  
12 subsection only if the Secretary determines the  
13 model satisfies the criteria described in subsection  
14 (d)(1)(B). The Secretary shall periodically make a  
15 available a list of such models so approved.

16 “(3) PARTICIPATING ENTITIES.—To participate  
17 under a demonstration program under this sub-  
18 section, with respect to an Alternative Payment  
19 Model, a physician, practitioner, or other supplier  
20 shall enter into a contract with the Administrator of  
21 the Centers for Medicare & Medicaid Services under  
22 this subsection. For purposes of this section, such a  
23 physician, practitioner, or supplier who so partici-  
24 pates under such an Alternative Payment Model

1 shall be referred to as a ‘participating APM pro-  
2 vider’.

3 “(4) REPORTING AND EVALUATION.—

4 “(A) INDEPENDENT EVALUATION ENTI-  
5 TY.—Under this subsection, the Secretary shall  
6 enter into a contract with an independent entity  
7 to evaluate Alternative Payment Models under  
8 demonstration programs under this subsection  
9 based on appropriate measures specified under  
10 subparagraph (B). In this section, such entity  
11 shall be referred to as the ‘independent evalua-  
12 tion entity’. Such contract shall be entered into  
13 in a timely manner so as to ensure evaluation  
14 of an Alternative Payment Model under a dem-  
15 onstration program under this subsection may  
16 begin as soon as possible after the model is ap-  
17 proved under paragraph (2).

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

21 “(i) measures to evaluate Alternative  
22 Payment Models under demonstration pro-  
23 grams under this subsection, which may  
24 include measures suggested under sub-  
25 section (c) and shall be sufficient to allow



1 for a comprehensive assessment of such a  
2 model; and

3 “(ii) quality measures on which par-  
4 ticipating entities shall report, which shall  
5 be similar to measures applicable under  
6 section 1848(k).

7 “(C) REPORTING REQUIREMENTS.—A con-  
8 tract entered into with a participating APM  
9 provider under paragraph (3) shall require such  
10 provider to report on appropriate measures  
11 specified under subparagraph (B).

12 “(D) PERIODIC REVIEW.—The inde-  
13 pendent evaluation entity shall periodically re-  
14 view and analyze and submit such analysis to  
15 the Secretary and the participating entities in-  
16 volved data reported under subparagraph (C)  
17 and such other data as deemed necessary to  
18 evaluate the model.

19 “(E) FINAL EVALUATION.—Not later than  
20 6 months after the date of completion of a dem-  
21 onstration program, the independent evaluation  
22 entity shall submit to the Secretary, the Medi-  
23 care Payment Advisory Commission, and the  
24 Chief Actuary of the Centers for Medicare &  
25 Medicaid Services (and make publicly available)

1 a report on each model evaluated under such  
2 program. Such report shall include—

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

6 “(ii) recommendations on—

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

10 “(II) whether or not the evalua-  
11 tion of such model under the dem-  
12 onstration program should be ex-  
13 tended or expanded;

14 “(iii) the justification for each such  
15 recommendation described in clause (ii);  
16 and

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

21 “(5) APPROVAL OF EXTENDING EVALUATION  
22 UNDER DEMONSTRATION.—Not later than 90 days  
23 after the date of receipt of a submission under para-  
24 graph (4)(E), the Secretary shall, including based on  
25 a recommendation submitted under such paragraph,

1 determine whether an Alternative Payment Model  
2 may be extended or expanded under the demonstra-  
3 tion program.

4 “(6) TERMINATION.—The Secretary shall ter-  
5 minate a demonstration program for a model under  
6 this subsection unless the Secretary determines (and  
7 the Chief Actuary of the Centers for Medicare &  
8 Medicaid Services, with respect to program spending  
9 under this title, certifies), after testing has begun,  
10 that the model is expected to—

11 “(A) improve the quality of care (as deter-  
12 mined by the Administrator of the Centers for  
13 Medicare & Medicaid Services) without increas-  
14 ing spending under this title;

15 “(B) reduce spending under this title with-  
16 out reducing the quality of care; or

17 “(C) improve the quality of care and re-  
18 duce spending.

19 Such termination may occur at any time after such  
20 testing has begun and before completion of the test-  
21 ing.

22 “(7) FUNDING.—

23 “(A) IN GENERAL.—There are appro-  
24 priated, from amounts in the Federal Supple-  
25 mentary Medical Insurance Trust Fund under

1 section 1841 not otherwise appropriated,  
2 \$2,000,000,000 for the purposes described in  
3 subparagraph (B), of which no more than 2.5  
4 percent may be used for the purpose described  
5 in clause (iii) of such subparagraph. Amounts  
6 transferred under this subparagraph shall be  
7 available until expended.

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

10 “(i) payments for items and services  
11 furnished by participating entities under  
12 an Alternative Payment Model under a  
13 demonstration program under this sub-  
14 section that—

15 “(I) would not otherwise be eligi-  
16 ble for payment under this title; or

17 “(II) exceed the amount of pay-  
18 ment that would otherwise be made  
19 for such items and services under this  
20 title if such items and services were  
21 not furnished under such demonstra-  
22 tion program;

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

1           “(iii) payment to the contracting enti-  
2           ty for carrying out its duties under this  
3           section; and

4           “(iv) for otherwise carrying out this  
5           subsection.

6           “(C) LIMITATION.—The amounts appro-  
7           priated under subparagraph (A) are the only  
8           amounts authorized or appropriated to carry  
9           out the purposes described in subparagraph  
10          (B).

11          “(f) IMPLEMENTATION OF RECOMMENDED MODELS  
12 AS ELIGIBLE APMs.—

13           “(1) IN GENERAL.—Not later than the applica-  
14          ble date under paragraph (2), the Secretary shall,  
15          implement an Alternative Payment Model rec-  
16          ommended under subsection (d)(1)(A)(ii) or  
17          (e)(4)(E)(ii)(I) as an eligible APM only if—

18           “(A) the Secretary determines that such  
19          model is expected to—

20           “(i) reduce spending under this title  
21          without reducing the quality of care; or

22           “(ii) improve the quality of patient  
23          care without increasing spending;

24           “(B) the Chief Actuary of the Centers for  
25          Medicare & Medicaid Services certifies that

1 such model would reduce (or would not result  
2 in any increase in) program spending under  
3 this title; and

4 “(C) the Secretary determines that such  
5 model would not deny or limit the coverage or  
6 provision of benefits under this title for applica-  
7 ble individuals.

8 Not later than 90 days after the date of issuance of  
9 a proposed rule, with respect to an Alternative Pay-  
10 ment Model, the Medicare Payment Advisory Com-  
11 mission shall submit comments to Congress and the  
12 Secretary evaluating the reports from the con-  
13 tracting entity and independent evaluation entity on  
14 such model regarding the model’s impact on expend-  
15 itures and quality of care under this title.

16 “(2) APPLICABLE DATE.—For purposes of  
17 paragraph (1), the applicable date under this para-  
18 graph—

19 “(A) for an Alternative Payment Model  
20 recommended under subsection (d)(1)(A)(ii) is  
21 90 days after the date of submission of such  
22 recommendation; and

23 “(B) for an Alternative Payment Model  
24 recommended under subsection (e)(4)(E)(ii)(I)

1 is 90 days after the date of submission of such  
2 recommendation

3 “(3) JUSTIFICATION FOR DISAPPROVALS.—In  
4 the case that an Alternative Payment Model rec-  
5 ommended under subsection (d)(1)(A)(ii) or  
6 (e)(4)(E)(ii)(I) is not implemented as an eligible  
7 APM under this subsection, the Secretary shall  
8 make publicly available the rationale, in detail, for  
9 such decision.

10 “(g) PERIODIC REVIEW AND TERMINATION.—

11 “(1) PERIODIC REVIEW.—In the case of an Al-  
12 ternative Payment Model that has been imple-  
13 mented, the Secretary and the Chief Actuary of the  
14 Centers for Medicare & Medicaid Services shall re-  
15 view such model every 3 years to determine (and  
16 certify, in the case of the Chief Actuary and spend-  
17 ing under this title), for the previous 3 years, wheth-  
18 er the model has—

19 “(A) reduced the quality of care, or

20 “(B) increased spending under this title,  
21 compared to the quality of care or spending that  
22 would have resulted if the model had not been imple-  
23 mented.

24 “(2) TERMINATION.—

1           “(A) QUALITY OF CARE REDUCTION TER-  
2           MINATION.—If based upon such review the Sec-  
3           retary determines under paragraph (1)(A) that  
4           the model has reduced the quality of care, the  
5           Secretary may terminate such model.

6           “(B) SPENDING INCREASE TERMI-  
7           NATION.—Unless such Chief Actuary certifies  
8           under paragraph (1)(B) that the expenditures  
9           under this title under the model do not exceed  
10          the expenditures that would otherwise have  
11          been made if the model had not been imple-  
12          mented for the period involved, the Secretary  
13          shall terminate such model.

14          “(h) DISSEMINATION OF ELIGIBLE APMS.—Under  
15          this section there shall be established a process for speci-  
16          fying, and making publicly available a list of, all eligible  
17          APMs, which shall include at least those implemented  
18          under subsection (f) and demonstrations carried out with  
19          respect to payments under section 1848 through authority  
20          in existence as of the day before the date of the enactment  
21          of this section. Under such process such list shall be peri-  
22          odically updated and, beginning with January 1, 2015,  
23          and annually thereafter, such list shall be published in the  
24          Federal Register.”.



1           (2) CONFORMING AMENDMENT.—Section  
2           1848(a)(1) of the Social Security Act (42 U.S.C.  
3           1395w-4(a)(1)) is amended by striking “shall in-  
4           stead” and inserting “shall, subject to section  
5           1848A, instead”.

6 **SEC. 3. EXPANDING AVAILABILITY OF MEDICARE DATA.**

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

9           (1) IN GENERAL.—To the extent consistent  
10          with applicable information, privacy, security, and  
11          disclosure laws, beginning with 2014, notwith-  
12          standing the second sentence of paragraph (4)(D) of  
13          section 1874(e) of the Social Security Act (42  
14          U.S.C. 1395kk(e)), a qualified entity may use data  
15          received by such entity under such section, and in-  
16          formation derived from the evaluation described in  
17          such paragraph (4)(D), for additional analyses (as  
18          determined appropriate by the Secretary of Health  
19          and Human Services) that such entity may provide  
20          or sell to providers of services and suppliers (includ-  
21          ing for the purposes of assisting providers of services  
22          and suppliers to develop and participate in quality  
23          and patient care improvement activities, including  
24          developing new models of care).

25          (2) DEFINITIONS.—In this section:

1 (A) The term “qualified entity” has the  
2 meaning given such term in section 1874(e)(2)  
3 of the Social Security Act (42 U.S.C.  
4 1395kk(e)).

5 (B) The terms “supplier” and “provider of  
6 services” have the meanings given such terms  
7 in subsections (d) and (u), respectively, of sec-  
8 tion 1861 of the Social Security Act (42 U.S.C.  
9 1395x).

10 (b) ACCESS TO MEDICARE DATA TO PROVIDERS OF  
11 SERVICES AND SUPPLIERS TO FACILITATE DEVELOP-  
12 MENT OF ALTERNATIVE PAYMENT MODELS AND TO  
13 QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE  
14 QUALITY IMPROVEMENT.—Consistent with applicable  
15 laws and regulations with respect to privacy and other rel-  
16 evant matters, the Secretary shall provide Medicare claims  
17 data for non-public use (in a form and manner determined  
18 to be appropriate) to—

19 (1) qualified entities, that may share with pro-  
20 viders of services and suppliers that are registered or  
21 authorized users or subscribers, in order to facilitate  
22 the development of new models of care (including de-  
23 velopment of Alternate Payment Models under sec-  
24 tion 1848A of the Social Security Act, models for

1 small group specialty practices, and care coordina-  
2 tion models); and

3 (2) qualified clinical data registries under sec-  
4 tion 1848(m)(3)(E) of the Social Security Act (42  
5 U.S.C. 1395w-4(m)(3)(E)) for purposes of linking  
6 such data with clinical outcomes data and per-  
7 forming analysis and research to support quality im-  
8 provement.

9 **SEC. 4. ENCOURAGING CARE COORDINATION AND MED-**  
10 **ICAL HOMES.**

11 Section 1848(b) of the Social Security Act (42 U.S.C.  
12 1395w-4(b)) is amended by adding at the end the fol-  
13 lowing new paragraph:

14 “(8) ENCOURAGING CARE COORDINATION AND  
15 MEDICAL HOMES.—

16 “(A) IN GENERAL.—In order to promote  
17 the coordination of care by an applicable physi-  
18 cian (as defined in subparagraph (B)) for indi-  
19 viduals with complex chronic care needs who  
20 are furnished items and services by multiple  
21 physicians and other suppliers and providers of  
22 services, the Secretary shall—

23 “(i) develop one or more HCPCS  
24 codes for complex chronic care manage-

1           ment services for individuals with complex  
2           chronic care needs; and

3           “(ii) for such services furnished on or  
4           after January 1, 2015, by an applicable  
5           physician, make payment (as the Secretary  
6           determines to be appropriate) under the  
7           fee schedule under this section using such  
8           HCPCS codes.

9           “(B) APPLICABLE PHYSICIAN DEFINED.—  
10          For purposes of this paragraph, the term ‘ap-  
11          plicable physician’ means a physician (as de-  
12          fined in section 1861(r)(1)) who—

13               “(i) is certified as a medical home (by  
14               achieving an accreditation status of level 3  
15               by the National Committee for Quality As-  
16               surance);

17               “(ii) is recognized as a patient-cen-  
18               tered specialty practice by the National  
19               Committee for Quality Assurance;

20               “(iii) has received equivalent certifi-  
21               cation (as determined by the Secretary); or

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

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

5           “(D) SINGLE APPLICABLE PHYSICIAN PAY-  
6           MENT.—In carrying out this paragraph, the  
7           Secretary shall only make payment to a single  
8           applicable physician for complex chronic care  
9           management services furnished to an indi-  
10          vidual.”.

11 **SEC. 5. MISCELLANEOUS.**

12          (a) SOLICITATIONS, RECOMMENDATIONS, AND RE-  
13          PORTS.—

14               (1) SOLICITATION FOR RECOMMENDATIONS ON  
15          EPISODES OF CARE DEFINITION.—The Adminis-  
16          trator of the Centers for Medicare & Medicaid Serv-  
17          ices shall request eligible professional organizations  
18          (as defined in section 1848(k)(3) of the Social Secu-  
19          rity Act (42 U.S.C. 1395w-4(k)(3))) and other rel-  
20          evant stakeholders to submit recommendations for  
21          defining non-acute related episodes of care for pur-  
22          poses of applying such definition under subsections  
23          (k) and (q) of section 1848 of the Social Security  
24          Act (42 U.S.C. 1395w-4) and section 1848A of such

1 Act, as added by subsections (b) and (c) of section  
2 2.

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

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

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

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

21 (A) BIENNIAL PROGRESS REPORTS.—Not  
22 later than January 15, 2016, and annually  
23 thereafter, the Secretary of Health and Human  
24 Services shall submit to Congress and post on  
25 the public Internet website of the Centers for

1 Medicare & Medicaid Services a biannual  
2 progress report—

3 (i) on the implementation of para-  
4 graph (9) of section 1848(k) of the Social  
5 Security Act (42 U.S.C. 1395w-4(k)), as  
6 added by section 2(b)(2), and the quality  
7 update incentive program under subsection  
8 (q) of section 1848 of the Social Security  
9 Act (42 U.S.C. 1395w-4), as added by sec-  
10 tion 2(b)(3);

11 (ii) that includes an evaluation of  
12 such paragraph and such quality update  
13 incentive program and recommendations  
14 with respect to such program and appro-  
15 priate update mechanisms; and

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

21 (B) GAO AND MEDPAC REPORTS.—

22 (i) GAO REPORT ON INITIAL STAGES  
23 OF PROGRAM.—The Comptroller General  
24 of the United States shall submit to Con-  
25 gress a report analyzing the extent to

1           which the system under section 1848(k)(9)  
2           of the Social Security Act (42 U.S.C.  
3           1395w-4(k)(9)) and such quality update  
4           incentive program under section 1848(q) of  
5           the Social Security Act, as added by sec-  
6           tion 2(b), as of such date, is successfully  
7           satisfying performance objectives, including  
8           with respect to—

9                       (I) the process for developing and  
10                      selecting measures and activities  
11                      under subsection (k)(9) of section  
12                      1848 of such Act (42 U.S.C. 1395w-  
13                      4);

14                     (II) the process for assessing per-  
15                      formance against such measures and  
16                      activities under subsection (q) of such  
17                      section; and

18                     (III) the adequacy of the meas-  
19                      ures and activities so selected.

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

23                     (I) GAO.—The Comptroller Gen-  
24                      eral of the United States shall evalu-  
25                      ate the initial phase of the quality up-



1 date incentive program under sub-  
2 section (q) of section 1848 of the So-  
3 cial Security Act (42 U.S.C. 1395w-  
4) and shall submit to Congress, not  
5 later than 2019, a report with rec-  
6 ommendations for improving such  
7 quality update incentive program.

8 (II) MEDPAC.—In the course of  
9 its March Report to Congress on  
10 Medicare payment policy, MedPAC  
11 shall analyze the initial phase of such  
12 quality update incentive program and  
13 make recommendations, as appro-  
14 priate, for improving such quality up-  
15 date incentive program.

16 (iii) MEDPAC REPORT ON PAYMENT  
17 SYSTEM ALTERNATIVES.—

18 (I) IN GENERAL.—Not later than  
19 June 15, 2016, the Medicare Payment  
20 Advisory Commission shall submit to  
21 Congress a report that analyzes mul-  
22 tiple options for alternative payment  
23 models in lieu of section 1848 of the  
24 Social Security Act (42 U.S.C.  
25 1395w-4). In analyzing such models,

1 the Medicare Payment Advisory Com-  
2 mission shall examine at least the fol-  
3 lowing models:

4 (aa) Accountable care orga-  
5 nization payment models.

6 (bb) Primary care medical  
7 home payment models.

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

11 (dd) Gainsharing arrange-  
12 ments

13 (II) ITEMS TO BE INCLUDED.—

14 Such report shall include information  
15 on how each recommended new pay-  
16 ment model will achieve maximum  
17 flexibility to reward high-quality, effi-  
18 cient care.

19 (C) TRACKING EXPENDITURE GROWTH  
20 AND ACCESS.—Beginning in 2015, the Chief  
21 Actuary of the Centers for Medicare & Medicaid  
22 Services shall track expenditure growth and  
23 beneficiary access to physicians' services under  
24 section 1848 of the Social Security Act (42  
25 U.S.C. 1395w-4) and shall post on the public

1 Internet website of the Centers for Medicare &  
2 Medicaid Services annual reports on such top-  
3 ics.

4 (b) RELATIVE VALUES UNDER THE MEDICARE PHY-  
5 SICIAN FEE SCHEDULE.—

6 (1) ELIGIBLE PHYSICIANS REPORTING SYSTEM  
7 TO IMPROVE ACCURACY OF RELATIVE VALUES.—Sec-  
8 tion 1848(c) of the Social Security Act (42 U.S.C.  
9 1395w-4(c)) is amended by adding at the end the  
10 following new paragraph:

11 “(8) PHYSICIAN REPORTING SYSTEM TO IM-  
12 PROVE ACCURACY OF RELATIVE VALUES.—

13 “(A) IN GENERAL.—The Secretary shall  
14 implement a system for the periodic reporting  
15 by physicians of data on the accuracy of relative  
16 values under this subsection, such as data relat-  
17 ing to service volume and time. Such data shall  
18 be submitted in a form and manner specified by  
19 the Secretary and shall, as appropriate, incor-  
20 porate data from existing sources of data, pa-  
21 tient scheduling systems, cost accounting sys-  
22 tems, and other similar systems.

23 “(B) IDENTIFICATION OF REPORTING CO-  
24 HORT.—Not later than January 1, 2015, the  
25 Secretary shall establish a mechanism for physi-

1           cians to participate under the reporting system  
2           under this paragraph, all of whom shall collec-  
3           tively be referred to under this paragraph as  
4           the ‘reporting group’. The reporting group shall  
5           include physicians across settings that collec-  
6           tively represent a range of specialties and prac-  
7           titioner types, furnish a range of physicians’  
8           services, and serve a range of patient popu-  
9           lations.

10           “(C) INCENTIVE TO REPORT.—Under the  
11           system under this paragraph, the Secretary  
12           may provide for such payments under this part  
13           to physicians included in the reporting group as  
14           the Secretary determines appropriate to com-  
15           pensate such physicians for reporting data  
16           under the system. Such payments shall be pro-  
17           vided in such form and manner as specified by  
18           the Secretary. In carrying out this subpara-  
19           graph, reporting by such a physician under this  
20           paragraph shall not be treated as the furnishing  
21           of physicians’ services for purposes of applying  
22           this section.

23           “(D) FUNDING.—To carry out this para-  
24           graph (other than with respect to payments  
25           made under subparagraph (C)), in addition to

1 funds otherwise appropriated, the Secretary  
2 shall provide for the transfer from the Federal  
3 Supplementary Medical Insurance Trust Fund  
4 under section 1841 of \$1,000,000 to the Cen-  
5 ters for Medicare & Medicaid Services Program  
6 Management Account for each fiscal year begin-  
7 ning with fiscal year 2014. Amounts trans-  
8 ferred under this subparagraph for a fiscal year  
9 shall be available until expended.”.

10 (2) RELATIVE VALUE ADJUSTMENTS FOR  
11 MISVALUED PHYSICIANS’ SERVICES.—

12 (A) IN GENERAL.—Section 1848(c)(2) of  
13 the Social Security Act (42 U.S.C. 1395w-  
14 4(c)(2)) is amended by adding at the end the  
15 following new subparagraph:

16 “(M) ADJUSTMENTS FOR MISVALUED PHY-  
17 SICIANS’ SERVICES.—With respect to fee sched-  
18 ules established for 2016, 2017, and 2018, the  
19 Secretary shall—

20 “(i) identify, based on the data re-  
21 ported under paragraph (8) and other rel-  
22 evant data, misvalued services for which  
23 adjustments to the relative values estab-  
24 lished under this paragraph would result in  
25 a net reduction in expenditures under the

1 fee schedule under this section, with re-  
2 spect to such year, of not more than 1 per-  
3 cent of the projected amount of expendi-  
4 tures under such fee schedule for such  
5 year; and

6 “(ii) make such adjustments for each  
7 such year so as to result in such a net re-  
8 duction for such year.”.

9 (B) BUDGET NEUTRALITY.—Section  
10 1848(c)(2)(B)(v) of the Social Security Act (42  
11 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by  
12 adding at the end the following new subclause:

13 “(VIII) REDUCTIONS FOR  
14 MISVALUED PHYSICIANS’ SERVICES.—  
15 Reduced expenditures attributable to  
16 subparagraph (M).”.

17 (c) RULE OF CONSTRUCTION REGARDING HEALTH  
18 CARE PROVIDER STANDARDS OF CARE.—

19 (1) IN GENERAL.—The development, recogni-  
20 tion, or implementation of any guideline or other  
21 standard under any Federal health care provision  
22 shall not be construed to establish the standard of  
23 care or duty of care owed by a health care provider  
24 to a patient in any medical malpractice or medical  
25 product liability action or claim.

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

3           (A) The term “Federal health care provi-  
4 sion” means any provision of the Patient Pro-  
5 tection and Affordable Care Act (Public Law  
6 111–148), title I and subtitle B of title III of  
7 the Health Care and Education Reconciliation  
8 Act of 2010 (Public Law 111–152), and titles  
9 XVIII and XIX of the Social Security Act.

10          (B) The term “health care provider”  
11 means any individual or entity—

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

15           (ii) required to be so licensed, reg-  
16 istered, or certified but that is exempted  
17 by other statute or regulation.

18          (C) The term “medical malpractice or  
19 medical liability action or claim” means a med-  
20 ical malpractice action or claim (as defined in  
21 section 431(7) of the Health Care Quality Im-  
22 provement Act of 1986 (42 U.S.C. 11151(7)))  
23 and includes a liability action or claim relating  
24 to a health care provider’s prescription or provi-  
25 sion of a drug, device, or biological product (as

1           such terms are defined in section 201 of the  
2           Federal Food, Drug, and Cosmetic Act or sec-  
3           tion 351 of the Public Health Service Act).

4           (D) The term “State” includes the District  
5           of Columbia, Puerto Rico, and any other com-  
6           monwealth, possession, or territory of the  
7           United States.

8           (3) NO PREEMPTION.—No provision of the Pa-  
9           tient Protection and Affordable Care Act (Public  
10          Law 111–148), title I or subtitle B of title III of the  
11          Health Care and Education Reconciliation Act of  
12          2010 (Public Law 111–152), or title XVIII or XIX  
13          of the Social Security Act shall be construed to pre-  
14          empt any State or common law governing medical  
15          professional or medical product liability actions or  
16          claims.

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