[DISCUSSION DRAFT]

SEC. 1. 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 such succeeding year''; and

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

(2) UPDATE OF RATES FOR [____ THROUGH ____].—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 [____ THROUGH ____].—The update to the single conversion factor established in paragraph (1)(C) for each of 2014 [through ____] shall be [_____].''.

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

(1) IN GENERAL.—Section 1848 of such 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) CONVERSION FACTOR BEGINNING WITH [____].—The single conversion factor established in paragraph (1)(C) for each year beginning with [____] shall be the single conversion factor so es-

tablished for [____] as adjusted under section 1848A(d).''; 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 section 1848A. [*Review inclusion here if this is now a new section.*]''.]

(2) ESTABLISHMENT OF PROGRAM.—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. FEE SCHEDULE PROVIDER COMPETENCY UPDATE INCENTIVE PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule provider competency update incentive program (in this section referred to as the 'update incentive program') under which—

"(A) for each peer cohort identified under subsection (b) and in accordance with subsection (d), there is approved and published a final competency measure set, which shall consist of quality measures and may also consist of clinical practice improvement activities;

"(B) each fee schedule provider—

"(i) self-identifies, in accordance with subsection (b), within such a peer cohort; and

"(ii) provides information on each quality measure and clinical practice improvement activity within such a final competency measure set applicable to such peer cohort with respect to which such provider shall be assessed for purposes of determining, for years beginning with **[**____**]**, the update adjustment under subsection (h) applicable to such provider;

"(C) there is developed and applied, in accordance with subsection (g), appropriate—

"(i) methodologies for assessing the performance of fee schedule providers with respect to such measures and activities included within the final competency meas-

ure sets applicable to the peer cohorts of such providers; and

"(ii) methods for collecting information needed for such assessments (which shall involve the minimum amount of administrative burden required to ensure reliable results); and

"(D) based on such assessments, there is determined the applicable update adjustments under subsection (h).

"(2) FEE SCHEDULE PROVIDER DEFINED.—In this section, the term 'fee schedule provider' means a physician, practitioner, or other supplier that furnishes items and services that are paid under the fee schedule established under section 1848.

"(3) CONSULTATION WITH FEE SCHEDULE PROVIDER ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Fee schedule provider organizations and other relevant stakeholders, including State medical societies, shall be consulted in carrying out this section.

"(4) ELECTION FOR APPLICATION AT GROUP PRACTICE OR INDIVIDUAL PHYSICIAN LEVEL.—For purposes of this section, in the case of a fee schedule provider who participates in a group practice (as de-

fined for purposes of section 1848(m)), a fee schedule provider may elect, in a form and manner specified under this section, to apply the measures and activities included within a final competency measure set under subsection (d), assessments of performance on quality (and, if applicable, clinical practice improvement activities), composite scores, and the update adjustments under this section at either the group practice level or individual provider level. Such election made by a fee schedule provider shall apply with respect to all such measures, activities, performance scores, and update adjustments for such provider.

''(b) PEER COHORTS.—

''(1) IN GENERAL.—[Not later than ____,] the Secretary shall identify (and publish a list of) peer cohorts by which fee schedule providers will self-identify for purposes of this section and with respect to a performance period (as defined in subsection (g)(3)) for a year beginning with [____]. Such self-identification will be made through such a process and at such time as specified under this section. Such list—

''(A) shall include as a peer cohort each provider specialty defined by the American

Board of Medical Specialties or equivalent certification boards as of [____] and such other cohorts as established under this section in order to capture classifications of providers across such fee schedule provider organizations and other practice areas or disease states; and

''(B) may be updated from time to time.

''(2) DEFINITION.—For purposes of this section, the term 'peer cohort' means a peer cohort identified on the list under paragraph (1), as updated under subparagraph (B) of such paragraph.

''(c) QUALITY MEASURES FOR COMPETENCY MEASURE SETS.—

''(1) DEVELOPMENT.—Under the update incentive program there shall be established a process for the development of quality measures under this paragraph for purposes of potential inclusion of such measures in measure sets under subsection (d). Under such process—

''(A) the development of such measures shall be coordinated across fee schedule providers and other relevant stakeholders;

''(B) fee schedule provider organizations and other relevant stakeholders representing the peer cohorts shall be requested to submit

best practices and clinical practice guidelines for the development of quality measures that address core competency categories (as defined under paragraph (3)) for potential inclusion in final competency measure sets under subsection (d);

''(C) all competency categories and peer cohorts shall be addressed by measures developed under this paragraph; and

''(D) all such measures developed under this paragraph shall be developed with consideration of best clinical practices.

''(2) CORE COMPETENCY CATEGORIES.—For purposes of this section, the term 'core competency categories' means the following categories: [*Review:*]

''(A) Clinical care.

''(B) Safety.

''(C) Care coordination.

''(D) Patient and caregiver experience.

''(E) Populations health and prevention.

''(d) COMPETENCY MEASURE SETS.—

''(1) IN GENERAL.—Under the update incentive program, there shall be established a process to approve final competency measure sets for peer co-

horts. Each such final competency measure set shall be composed of quality measures (and, as applicable, clinical practice improvement activities) with respect to which fee schedule providers within such peer cohort shall be assessed under subsection (g). Such process shall provide for—

''(A) the establishment of criteria, which shall be made publicly available before the request is made under paragraph (3), for selecting such measures and activities for potential inclusion in such a final competency measure set; and

''(B) to the greatest extent practicable and for potential inclusion in measure sets under this subsection with respect to each peer cohort, the selection of a sufficient number of quality measures that apply in a variety of practice arrangements and in all geographic areas.

''(2) SOLICITATION OF PUBLIC INPUT ON QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

''(A) IN GENERAL.—Under the process established under paragraph (1), not later than **[**____**]**, fee schedule provider organizations and other relevant stakeholders shall be requested to

identify and submit quality measures for selection under this subsection and may request such organizations and stakeholders to identify and submit to the Secretary clinical practice improvement activities for selection under this subsection. For purposes of the previous subparagraph, measures and activities may be submitted regardless of whether such measures were previously published in a proposed rule.

''(B) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this section, the term 'clinical practice improvement activity' means an activity that the appropriate fee schedule provider societies 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 health outcomes.

''(3) PROVISIONAL CORE MEASURE SETS.—

''(A) IN GENERAL.—Under the process established under paragraph (1), not later than **[____]**, the Secretary—

''(i) shall select, from quality measures described in subparagraph (B) applicable to a peer cohort, quality measures to

be included in a provisional core measure set for such cohort;

''(ii) shall, to the extent there are insufficient quality measures applicable to a peer cohort to address an applicable core competency category, select to be included in a provisional core measure set for such cohort such clinical practice improvement activities described in subparagraph (B)(iv) as is needed to sufficiently address such category with respect to such peer cohort; and

''(iii) may select, to the extent determined appropriate, any additional clinical practice improvement activities described in subparagraph (B)(iv) applicable to a peer cohort to be included in a provisional core measure set for such cohort.

Any activity selected under this paragraph shall be selected with consideration of best clinical practices.

''(B) SOURCES OF QUALITY MEASURES AND CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—A quality measure or clinical practice improvement activity selected for inclusion in a

provisional core measure set under the process under this subsection may be—

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

"(ii) a measure otherwise applied for a similar purpose under section 1848;

"(iii) a measure developed under subsection (c); or

"(iv) a measure or activity submitted under paragraph (2).

A measure or activity may, and should, be selected under this subparagraph, regardless of whether such measure or activity was previously published in a proposed rule.

"(C) TRANSPARENCY.—[*Any deadline for public availability?*] There shall be made publicly available, and submitted for publication in specialty-appropriate peer-reviewed journals, each applicable core measure set under subparagraph (A) and the method for developing and selecting measures, including clinical data supporting such measures, and, as applicable, selecting clinical practice improvement activities included within such set.

''(4) PUBLIC COMMENT.—Under the process established under paragraph (1), before a provisional core measure set under paragraph (3) may be approved as a final competency measure set under paragraph (5), there shall be a reasonable public comment period on the provisional core measure set.

''(5) FINAL MEASURE SETS.—At least 90 days prior to the first day of a performance period and taking into account public comment received pursuant to paragraph (4), the Secretary shall approve and publish a final competency measure set for each peer cohort.

''(e) PERIODIC REVIEW AND UPDATES.—

''(1) IN GENERAL.—In carrying out this section, there shall periodically be reviewed—

''(A) the quality measures and clinical practice improvement activities selected for inclusion in final competency measure sets under subsection (d) for each year such measures and activities are to be applied under subsection (g) to ensure that such measures and activities continue to meet the conditions applicable to such measures and activities for such selection; and

''(B) the final competency measures sets approved under subsection (d) for each year

such sets are to be applied to peer cohorts of fee schedule providers to ensure that each applicable set continues to meet the conditions applicable to such sets for such approval.

''(2) COLLABORATION WITH STAKEHOLDERS.—In carrying out paragraph (1), fee schedule provider organizations and other relevant stakeholders shall be requested to, as needed, identify and submit updates to quality measures and clinical practice improvement activities selected under subsection (d) as well as any additional quality measures and clinical practice improvement activities. Submissions under this paragraph shall be reviewed at least annually.

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

''(A) selected additional, and updates to, quality measures and clinical practice improvement activities selected under subsection (d) for potential inclusion in final competency measure sets in the same manner such quality measures and clinical practice improvement activities are selected under such subsection for such potential inclusion; and

"(B) modified final competency measure sets approved under paragraph (5) of subsection (d) in the same manner as such sets are approved under such subsection.

For purposes of this section, a final competency measure set, as modified under this paragraph, shall be treated in the same manner as a final competency measure set approved under subsection (d).

"(4) TRANSPARENCY.—

"(A) NOTIFICATION REQUIRED FOR CERTAIN MODIFICATIONS.—In the case of a modification under paragraph (3)(B) that removes a measure or activity from a measure set, such modification shall not apply under this section unless notification of such modification is made available to all applicable fee schedule providers.

"(B) PUBLIC AVAILABILITY OF MODIFIED MEASURE SETS.—Paragraph (3)(C) shall apply with respect measure sets modified under paragraph (3)(B) in the same manner as such paragraph applies to applicable core measure sets under paragraph (3)(A).

"(f) COORDINATION WITH EXISTING PROGRAMS.—The development and selection of quality measures and

clinical practice improvement activities under this section 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 section 1848(m)(5)(G) and the application of resource use management under section 1848(n)(9)(A). To the extent feasible, such measures and activities shall align with measures used under similar incentive programs of other payers and with measures and activities in use under other provisions of section 1848 in order to streamline the process of such development and selection under this section.

''(g) ASSESSING PERFORMANCE WITH RESPECT TO FINAL COMPETENCY MEASURE SETS FOR APPLICABLE PEER COHORTS.—

''(1) ESTABLISHMENT OF METHODS FOR ASSESSMENT.—

''(A) IN GENERAL.—The Secretary shall establish one or more methods, applicable to each year beginning with **[**____**]**, to assess the performance of a fee schedule provider with respect to each quality measure and clinical practice improvement activity included within the final competency measure set approved under subsection (d) applicable for the performance

period for such year to the peer cohort in which the provider self-identified under subsection (b) for such performance period and compute a composite score for such provider for such performance period with respect to the measures and activities included within such measure set. Such methods shall include methods for collecting fee schedule provider information in order to make such assessments.

''(B) METHODS.—Such methods shall, with respect to a fee schedule provider—

''(i) provide that the performance of such provider shall be assessed for a performance period with respect to the quality measures and clinical practice improvement activities within the final competency measure set for such period for the peer cohort of such provider and on which information is collected from such provider; and

''(ii) allow for the collection and utilization of data from registries or electronic health records.

''(C) WEIGHTING OF MEASURES.—Such a method—

''(i) may provide for the assignment of different scoring weights—

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

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

''(ii) shall consider the rigor of evidence linking assessment to quality; and

''(iii) shall provide for risk adjustment to account for differences in geographic location and patient populations.

''(D) 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, such as under subsection (k) of section 1848.

''(2) USE OF SPECIALTY REGISTRIES.—For purposes of this subsection, there shall be used, to the greatest extent possible, data from qualified clinical data registries that meet the requirements established under section 1848(m)(3)(E).

"(3) PERFORMANCE PERIOD.—Not later than **[**____**]**, there shall be established a period (in this section referred to as a 'performance period'), with respect to a year, to assess performance on quality measures and clinical practice improvement activities. Each such performance period shall occur prior to the beginning of the year and shall occur as close to the beginning of the year as is practical.

"(h) UPDATE ADJUSTMENT TAKING INTO ACCOUNT COMPETENCY ASSESSMENTS.—**[***Refer to attachment A for policy options.***]**

"(i) TRANSITION FOR NEW FEE SCHEDULE PROVIDERS.—In the case of a physician, practitioner, or other supplier that first becomes a fee schedule provider (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)—

"(1) in any part of **[**_____**]**, during the first calendar year in any part of which the physician, practitioner, or other supplier is a fee schedule provider, the update adjustment under this paragraph shall be, **[**for each such year, **[**_____**]]**; and

"(2) in any part of a subsequent year, the update adjustment shall be during a period (not to exceed a 1-year period) and in such amount as speci-

fied by the Secretary, taking into account the need for sufficient time for the provider to adjust to the incentive payment system under this section.

''(j) FEEDBACK; EDUCATION.—

''(1) FEEDBACK.—

''(A) INITIAL FEEDBACK.—Each fee schedule provider self-identified within a peer cohort shall, before any assessment of the fee schedule provider under subsection (g) for determining the applicable update adjustment under subsection (h) for such provider and the year involved, have a **[**____**]** period during which the provider shall report on the applicable quality measures and clinical practice improvement activities and receive feedback on the performance of such provider with respect to such measures and activities.

''(B) ONGOING FEEDBACK.—Under the update incentive program there shall be provided, as real time as possible, but at least quarterly, to each fee schedule provider feedback—

''(i) on the performance of such provider with respect to quality measures and clinical practice improvement activities

within the final competency measure set published under subsection (d)(5) for the applicable performance period and the peer cohort of such provider; and

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

"(C) USE OF REGISTRIES.—Feedback under this paragraph shall, to the greatest extent possible, be provided and based on performance received through the use of data registries, including registries under subsections (k) and (m) of section 1848.

"(D) APPLICATION TO PROVIDERS ELECTING APPLICATION ON GROUP PRACTICE LEVEL.—The feedback and performance data required to be provided by the Secretary under this paragraph shall be provided to a fee schedule provider regardless of the election made by the provider under subsection (a)(4).

"(2) DATA PORTAL.—Under the update incentive program, there shall be developed a web-based fee schedule provider portal through which such a provider may receive performance data, including

data with respect to performance on the measures and activities developed and selected under this section. Such portal shall be developed in consultation with private payers and health insurance issuers as appropriate.

''(3) EDUCATION PROGRAM.—Under the update incentive program, information shall be disseminated to educate and assist fee schedule providers about such program through multiple approaches, including a national dissemination strategy and outreach by Medicare contractors.

''(4) TRANSFER OF FUNDS.—The Secretary shall provide for the transfer of [_____] from the Federal Supplementary Medical Insurance Trust Fund established in section 1841 to the Center for Medicare & Medicaid Services Program Management Account for fiscal year [____] to support such efforts to develop the data infrastructure as necessary to carry out this subsection. Such funds shall remain available until expended.

''(k) INDEPENDENT AUDIT BY INSPECTOR GENERAL.—The Inspector General of the Department of Health and Human Services shall audit the activities of the Centers of Medicare & Medicaid Services in carrying out this section. Such audit shall occur at least once before

any assessment of a fee schedule provider is made under subsection (g) for determining the applicable update adjustment under subsection (h) and periodically thereafter.''.

(c) PHYSICIAN FEE SCHEDULE OPT OUT FOR PROVIDERS PARTICIPATING IN ALTERNATIVE PAYMENT MODELS.—

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

''SEC. 1848B. OPT OUT OF PHYSICIAN FEE SCHEDULE FOR PROVIDERS PAID UNDER ALTERNATIVE PAYMENT MODELS.

''(a) OPT OUT.—

''(1) IN GENERAL.—Payment for physicians' services that are furnished by an alternative fee schedule provider under an Alternative Payment Model specified on the list under subsection (h) (in this section referred to as an 'opt-out eligible APM') shall be made in accordance with the payment arrangement under such model in lieu of under the fee schedule under section 1848.

''(2) ALTERNATIVE FEE SCHEDULE PROVIDER DEFINED.—For purposes of this section, the term

'alternative fee schedule provider' means a physician, practitioner, or other supplier who would be considered a fee schedule provider (as defined in section 1848A(a)(2)), with respect to items and services, if the physician, practitioner, or supplier did not have in effect a payment arrangement described in paragraph (1) for such items and services.

''(b) PROCESS FOR IDENTIFYING OPT-OUT ELIGIBLE APMS.—For purposes of subsection (a) and in accordance with this section, the Secretary shall establish a process under which—

''(1) a contract is entered into, in accordance with the process under section 1890(a), with an entity (in this section referred to as the 'APM contracting entity') to carry out the functions applicable to such entity under this section;

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

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

''(4) applicable Alternative Payment Models are evaluated under such demonstration program;

''(5) models are identified as opt-out eligible APMs in accordance with subsection (f); and

''(6) a comprehensive list of all opt-out eligible APMs is made publicly available, in accordance with subsection (h), for application under subsection (a).

''(c) SUBMISSION OF PROPOSED ALTERNATIVE PAYMENT MODELS.—

''(1) IN GENERAL.—Beginning not later than **[____]**, the APM contracting entity shall at least annually request physicians, fee schedule provider organizations (as defined in section 1848A(a)(3)), health care provider organizations, and other entities to submit to the APM contracting entity proposals for Alternative Payment Models for application under this section. Such a proposal of a model may include proposed measures to be used to evaluate such model.

''(2) ACCESS TO INFORMATION.—The Centers for Medicare & Medicaid Services shall permit physicians, fee schedule provider organizations, health care provider organizations, and other entities submitting proposals under subsection (b) to have access to deidentified claims data in order to facilitate

the formulation of a proposal for an Alternative Payment Model for such a submission.

''(d) RECOMMENDATION AND APPROVAL OF PROPOSED MODELS.—

''(1) RECOMMENDATION.—

''(A) IN GENERAL.—Under the process under subsection (b), the APM contracting entity shall at least annually recommend—

''(i) based on the criteria described in subparagraph (C), Alternative Payment Models proposed under subsection (c) to be evaluated through a demonstration program under subsection (e), including the duration for such evaluation, which shall not be more than 3 years; and

''(ii) based on the criteria described in subparagraph (D), such models for identification under subsection (f), without evaluation through a demonstration program.

''(B) TRANSPARENCY.—In any case that the APM contracting entity does not recommend under subparagraph (A) a model proposed under subsection (b), the entity shall submit to the Secretary and make publicly avail-

able an explanation of the reasons for not making such a recommendation.

''(C) CRITERIA FOR RECOMMENDING MODELS FOR DEMONSTRATION.—The APM contracting entity shall make a recommendation under subparagraph (A)(i), with respect to an Alternative Payment Model, if the entity determines that the model satisfies each of the following criteria:

''(i) The model has been supported by meaningful clinical and non-clinical data that indicates the model would be successful at addressing each of the abilities described in clause (v).

''(ii) The individuals who were furnished services under such model, or would be furnished services under such model if the model were evaluated under the demonstration under subsection (e), would represent at least [____] percent of the individuals [enrolled under this part]. [*How many patients would make a sufficient minimum sample size to test appropriately?*]

''(iii) Such model, including if 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) At least one fee schedule provider[, alternative fee schedule provider,] or organization employing such a provider indicates a commitment to participate in the proposed Alternative Payment Model if the Alternative Payment Model were to be identified as an opt-out eligible APM under this section.

''(v) The proposal for such model demonstrates the potential to successfully manage the cost of furnishing items and services under this title, the ability to improve the overall patient experience, and the ability to improve the quality of care provided to individuals enrolled under this part who participate under such model.

''(D) CRITERIA FOR RECOMMENDING MODELS FOR APPROVAL WITHOUT EVALUATION UNDER DEMONSTRATION.—The APM contracting entity may make a recommendation

under subparagraph (A)(ii), with respect to an Alternative Payment Model, if the entity determines that the model has already been evaluated for **[**____**]/[**a sufficient enough period**]** and through such evaluation the model was shown—

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

"(ii) to demonstrate each of the abilities described in clause (v) of such subparagraph.

"(2) SUBMISSION OF RECOMMENDED MODELS.—

"(A) MODELS REQUIRING WAIVER APPROVAL.—

"(i) IN GENERAL.—In the case that an Alternative Payment Model recommended under paragraph (1)(A) requires waiver authority from any requirements under this title for purposes of the demonstration program under subsection (e) or from any requirements under the demonstration program, the APM contracting entity shall submit such model to

the Secretary for approval of such waiver in order for such model to be evaluated under the demonstration program (if described in clause (i) of such paragraph) or for purposes of the determination under subsection (f) (if described in clause (ii) of such paragraph).

''(ii) APPROVAL.—Not later than 90 days after the date of the receipt of such submission for a model, the Secretary shall notify the APM contracting entity whether or not such waiver authority for such model is so approved [and the reason for any denial of such a waiver].

''(B) FINAL LISTS OF MODELS FOR EVALUATION UNDER DEMONSTRATION.—The APM contracting entity shall at least annually submit to the Secretary, the Medicare Payment Advisory Commission, and the Chief Actuary of the Centers for Medicare & Medicaid Services the following:

''(i) A list of the models recommended under paragraph (1)(A)(i) that do not require waiver authority described in subparagraph (A) and the models rec-

ommended under such paragraph that require such waiver authority, which have been approved under subparagraph (A)(ii).

"(ii) A list of the models recommended under paragraph (1)(A)(ii) that do not require waiver authority described in subparagraph (A) and the models recommended under such paragraph that require such waiver authority, which have been approved under subparagraph (A)(ii).

For any year [beginning with ____] that the APM contracting does not recommend any models to be included on a list to submit under this subparagraph, the entity shall instead satisfy this subparagraph by submitting to the Secretary and making publicly available an explanation for not having any such recommendations.

"(e) DEMONSTRATION.—

"(1) IN GENERAL.—Subject to paragraph (5) and subsection (g), each model included on the list under subsection (d)(2)(B)(i) shall be evaluated under a demonstration program, the duration of which shall be [3 years] (or such other period, tak-

ing into account the applicable recommendation under subsection (d)(1)(A)(i)).

''(2) PARTICIPATING ENTITIES.—Fee schedule providers [or alternative fee schedule providers] that enter into a contract with the APM contracting entity may participate under an Alternative Payment Model under the demonstration program. For purposes of this section, such a provider who so participates under such an Alternative Payment Model shall be referred to as a 'participating APM provider'.

''(3) REPORTING AND PERIODIC REVIEW.—

''(A) IN GENERAL.—Under the demonstration program, participating APM providers shall be required to report on such measures as specified by the APM contracting entity as sufficient to demonstrate data end points, as agreed to by the participating APM provider involved and the APM contracting entity, to evaluate such model.

''(B) TRANSPARENCY OF DATA.—The APM contracting entity shall periodically review and submit under the authority established under section 1890(a) such reported data (and

such other data as deemed necessary by the entity for to evaluate the model).

''(4) FINAL EVALUATION.—Not later than [____] after the date of completion of a demonstration program, the APM contracting 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—

''(A) outcomes on the clinical data received through such program with respect to such model;

''(B) recommendations on—

''(i) whether or not such model should be identified as an opt-out eligible APM under this section; or

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

''(C) the justification for each such recommendation described in subparagraph (B); and

"(D) recommendations on standardized rules for purposes of implementing such model if it were identified as an opt-out eligible APM.

"(5) APPROVAL OF EXTENDING EVALUATION UNDER DEMONSTRATION.—The Secretary shall, including based on a recommendation submitted under paragraph (4), determine whether an Alternative Payment Model may be extended or expanded under the demonstration program.

"(f) IDENTIFICATION OF RECOMMENDED MODELS AS OPT-OUT ELIGIBLE APMS.—

"(1) IN GENERAL.—The Secretary shall—

"(A) [based on the reports submitted under paragraph (3)], determine which of the Alternative Payment Models described in paragraph (2) should be identified as opt-out eligible APMs for purposes of this section; and

"(B) of those so determined, identify such opt-out eligible APMs through rulemaking.

"(2) APMS DESCRIBED.—For purposes of paragraph (1), an Alternative Payment Model described in this paragraph is—

"(A) an Alternative Payment Model recommended under subsection (e)(4)(B)(i) to be identified as an opt-out eligible APM; and

''(B) an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) that is included on the list under subsection (d)(2)(B)(ii).

''(3) REPORTS.—The following reports shall be submitted to Congress and the Secretary:

''(A) CHIEF ACTUARY REPORT.—A report submitted by the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to each model described in paragraph (2), on whether the identification of such model as an opt-out eligible APM under this section is expected to reduce (or would not result in any increase in) net expenditures under this title.

''(B) MEDPAC REPORT.—A report submitted by the Medicare Payment Advisory Commission, with respect to each model described in paragraph (2), on whether the identification of such model as an opt-out eligible APM under this section is expected to—

''(i) not increase expenditures under this title;

''(ii) not reduce the quality of health care provided;

"(iii) improve the quality of patient care without increasing expenditures under this title; or

"(iv) decrease expenditures under this title without reducing the quality of health care provided.

"(4) JUSTIFICATION FOR DISAPPROVALS.—In the case of an Alternative Payment Model described in paragraph (2) that is determined should not be identified as an opt-out eligible APM, there shall be made publicly available the rational, in detail, for such disapproval.

"(g) TERMINATION AUTHORITY.—An Alternative Payment Model may not be considered an opt-out eligible APM and may not be eligible (or shall cease to be eligible) for evaluation under the demonstration program under subsection (e) if the Administrator of the Centers for Medicare & Medicaid Services certifies, that the model, based on available evidence, has been demonstrated to—

"(1) decrease the quality of health care;

"(2) increase expenditures under this title; or

"(3) deny or limit the coverage or provision of benefits under this title for applicable individuals.

"(h) DISSEMINATION OF OPT-OUT ELIGIBLE APMS.—Under this section there shall be established a

process for specifying, and making publicly available a list of, all opt-out eligible APMs, which shall include at least those identified under subsection (f) [*Review treatment of demonstrations:* and demonstrations carried out with respect to payments under this section 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 2015 and annually thereafter, such list shall be published in the Federal Register].

[''(i) AUTHORITY TO RETIRE OR MODIFY OPT-OUT ELIGIBLE APMS.—[_____]''.]

(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 1848B, instead''.

SEC. 2. SOLICITATIONS, RECOMMENDATIONS, AND REPORTS.

(a) SOLICITATION FOR RECOMMENDATIONS ON EPISODES OF CARE DEFINITION.—The Administrator of the Centers for Medicare & Medicaid Services shall request fee schedule provider organizations and other relevant stakeholders to submit recommendations for defining non-acute related episodes of care for purposes of applying such defi-

nition under sections 1848A and 1848B of the Social Security Act, as added by subsections (b) and (c) of section 1.

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

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall solicit from fee schedule provider organizations (as defined in section 1848A(a)(3) of the Social Security Act, as added by section 1(b)) recommendations for payment bundles for chronic conditions and expensive, high volume services [for which payment is made under title XVIII of such Act].

(2) 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 proposals for such payment bundles.

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

(1) BIANNUAL PROGRESS REPORTS.—Not later than [____], and every 6 months 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—

(A) on the implementation of the update incentive program under section 1848A of the Social Security Act (42 U.S.C. 1395w–4), as added by section 1(b)(2);

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

(C) on the actions taken to promote and fulfill the identification of opt-out eligible APMs under section 1848B of the Social Security Act, as added by section 1(c), for application under such section 1848B.

(2) GAO AND MEDPAC REPORTS.—

(A) GAO REPORT ON INITIAL STAGES OF PROGRAM.—Not later than [____], the Comptroller General of the United States shall submit to Congress a report analyzing the extent to which such update incentive program under section 1848A of the Social Security Act, as added by section 1(b)(2), as of such date, is successfully satisfying performance objectives, including with respect to—

(i) the process for developing and selecting measures and activities under subsections (c) and (d) of such section 1848A;

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

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

(B) EVALUATION BY GAO AND MEDPAC ON IMPLEMENTATION OF UPDATE INCENTIVE PROGRAM.—The Comptroller General of the United States and the Medicare Payment Advisory Commission shall each evaluate the initial phase of the update incentive program under such section 1848A and shall submit to Congress, not later than **[**____**]**, a report with recommendations for improving such update incentive program.

(C) MEDPAC REPORT ON PAYMENT SYSTEM ALTERNATIVES.—

(i) IN GENERAL.—Not later than **[**December 31, 2014**]**, 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:

(I) Alternative care organization payment models.

(II) Primary care medical home payment models.

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

(IV) 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.

(3) TRACKING EXPENDITURE GROWTH AND ACCESS.—Beginning in **[**____**]**, 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 Medi-

care & Medicaid Services annual reports on such topics.