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 [PERIOD OF STABILITY].—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 [PERIOD OF STABILITY].—The update to the single conversion factor established in paragraph (1)(C) for [the period of stability (as defined in ____)] 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 in subsection (d), by adding at the end the following new paragraph:

“(16) CONVERSION FACTOR BEGINNING WITH [FIRST YEAR AFTER PERIOD OF STABILITY].—The single conversion factor established in paragraph (1)(C) for each year beginning with [the first year after the period of stability] shall be [determined in accordance with section 1848A(e)].”.
(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) the Secretary shall, in accordance with subsection (b), approve and publish a final quality measure set for each peer cohort identified under paragraph (1) of such subsection;

“(B) each fee schedule provider—

“(i) self-identifies, in accordance with subsection (b)(1), within such a peer cohort; and

“(ii) provides information on each quality measure within such a final quality 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 first year after
the period of stability] the [quality-based update adjustment under subsection (e)] applicable to such provider;

“(C) the Secretary shall develop and apply, in accordance with subsection (d), appropriate—

[(“(i) methodologies for assessing the performance of fee schedule providers with respect to such measures included within the measure 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 needed to ensure reliable results); and

“(D) based on such assessments, the Secretary shall determine the applicable [quality-based update adjustments under subsection (e)].

“(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 medical specialty organizations and other relevant stakeholders.—The Secretary shall consult with medical specialty organizations and other relevant stakeholders, including State medical societies, in carrying out this section.

“(4) Modification for non-physician fee schedule providers who are authorized to bill Medicare directly for reimbursement.—Not later than [____], the Secretary shall determine how to apply the update incentive program to fee schedule providers who are not physicians described in section 1861(r)(1). [Duplicate with paragraph (3)]: In making such determination, the Secretary shall consult with relevant stakeholders.]

In applying this paragraph, the Secretary shall at a minimum determine if there are applicable quality measures [selected] under subsection (b) that can be utilized for determining applicable update adjustments to the fee schedule under [subsection (e)] for such fee schedule providers. If adequate measures are not available, the Secretary shall apply a similar [performance]/[competency]-based program to determine the [quality-based update adjustment under subsection (e)] for such fee schedule providers.
(5) Election for application at group practice or individual physician level.—If the Secretary chooses to specifically provide for an election opportunity, or remain silent (in which case the Secretary may decide to apply assessments at a group level, but the element specifically allowing the providers and groups to make an election would not be implied): For purposes of this section, in the case of a fee schedule provider who participates in a group practice, as defined by the Secretary, following the section 1848(o) or 1848(m) model? As such term is defined in section 1877(h)(4)?, a fee schedule provider may elect, in a form and manner specified by the Secretary, to apply at either the group practice level or individual provider level the applicable final quality measure set approved under subsection (b), performance on quality, composite scores, and the update adjustments under this section. Such election made by a fee schedule provider shall apply with respect to all measures within such set, performance scores, and update adjustments for such provider. The feedback and performance data required to be provided by the Secretary under subsections (b)(5) and (g) shall be provided to a fee schedule provider regardless of the
election made by the provider under this paragraph.

[Review: How would this apply in the case of a provider participating in multiple practices? Would the election be on an individual provider level or would all providers within a group have to collectively make this election? If the assessment is based on the group level, how is feedback to be provided for the individual?]

“(b) Quality Measures for Competency Assessments.—

“(1) Establishment of list of peer cohorts.—[Not later than ____], the Secretary shall identify ([and publish?] a list [Is this list to be updated?]) of peer cohorts (each in this section referred to as a ‘peer cohort’) with respect to which fee schedule providers will self-identify [through a process and at such time as specified by the Secretary Review: How is the self identification to be ‘approved by the Secretary’?] for purposes of this section and with respect to a performance period described in subsection (d)(3) for a year beginning with [the first year after the period of stability]. Such list shall include as a peer cohort the [each provider specialty [in which the American Board of Medical Specialties offers certification] [defined by]
the American Board of Medical Specialties as of
and any other cohort established by the Sec-
retary to capture classifications of providers across
such provider specialties.

“(2) Establishment of Core Competency
Categories and Identification of Areas of
Need for Quality Measures.—The Secretary
shall convene multi-stakeholder groups to—

“(A) establish core competency categories
for all peer cohorts, which shall identify
areas that are to be assessed by the quality
measures selected under this subsection for in-
clusion in final quality measure sets by which
fee schedule providers [in such cohorts] are to
be assessed under subsection (d); and

“(B) identify areas and peer cohorts for
which there are insufficient quality measures to
address the categories established under sub-
paragraph (A).

“(3) Quality Measures Development.—The
Secretary shall establish a process for the develop-
ment of quality measures under this paragraph for
purposes of potential inclusion of such measures [in
measure sets under paragraph (4)]. Under such
process, the Secretary shall—
“(A) provide for the coordination of development of such measures across fee schedule providers and other relevant stakeholders;

“(B) request from [medical specialty organizations and other relevant stakeholders]/[consensus-based entities] [representing the peer cohorts] best practices and clinical practice guidelines for the development of quality measures [within the core competency categories established under paragraph (2)] for potential inclusion of such measures in final quality measure sets under paragraph (4)(F);

“(C) ensure the core competency categories and peer cohorts are addressed; and

“(D) ensure that all quality measures developed under this paragraph are developed with consideration of best clinical practices.

“(4) [QUALITY MEASURES SELECTION][SELECTION AND APPROVAL OF QUALITY MEASURE SETS].—

“(A) IN GENERAL.—The Secretary shall, in accordance with this paragraph, provide for a quality measures process to approve final quality measure sets for peer cohorts. Each such final measure set shall be composed of the
quality measures with respect to which fee schedule providers within such peer cohort shall be assessed under subsection (d). Under such process the Secretary shall establish, and prior to making the request under subparagraph (C) make publicly available, criteria for selecting such measures [for potential inclusion in such final quality measure sets].

“(B) SOURCES OF MEASURES.—A quality measure selected [for inclusion in a [provisional] core quality measure set] under the process under this paragraph may be—

“(i) an [existing] [What if a measure is endorsed in the future?] quality measure that has been endorsed by [a consensus-based entity];

“(ii) a quality measure developed under paragraph (3); or

“(iii) a quality measure that is developed by a [medical specialty organization or other relevant stakeholder] [and submitted under subparagraph (C)];

“(C) SOLICITATION OF PUBLIC QUALITY MEASURE INPUT.—Not later than [____], the Secretary shall request [medical specialty orga-
organizations and other relevant stakeholders to identify and submit to the Secretary quality measures for selection under this paragraph.

“(D) PROVISIONAL CORE MEASURE SETS.—

“(i) IN GENERAL.—Under the process established under subparagraph (A), [not later than ____], the Secretary shall select quality measures described in subparagraph (B) [applicable to a peer cohort] to be included in a provisional core measure set [for such cohort]. Any [applicable] quality measure developed under the process established under paragraph (3) may be included in a provisional core measure set.

“(ii) TRANSPARENCY.—[Any deadline for public availability?] The Secretary shall make publicly available, including by publishing in specialty-appropriate peer-reviewed journals, [each applicable] provisional core measure set under clause (i) and the method for developing [and selecting] measures included within such set. ([Specs: ‘Create exception that in event soci-
ety declines, Secretary can still go forward in process.’ What does that exception mean? Is this in the case a specialty society does not want to publish the core set?"

“(E) PUBLIC COMMENT.—Under the process established under subparagraph (A), before a provisional core measure set under subparagraph (D) may be approved as a final quality measure set under subparagraph (F) the Secretary shall provide for a reasonable public comment period on the provisional core measure set.

“(F) FINAL MEASURE SETS.—At least [_____] days before the first day of a performance period described in subsection (d)(3) [and taking into account public comment received pursuant to subparagraph (E)], the Secretary shall approve and publish a final quality measure set for each peer cohort.

“(5) FEEDBACK.—

“(A) INITIAL FEEDBACK PERIOD.—Each fee schedule provider self-identified with respect to a peer cohort shall, before any assessment of the fee schedule provider under subsection (d) for determining the applicable update adjust-
ment under subsection (e) for such provider and the year involved, have a \[\_
\] period during which the provider shall report on the applicable quality measures and receive feedback on the performance of such provider with respect to such measures.

“(B) FEEDBACK.—The Secretary shall provide each fee schedule provider with feedback on the performance of such provider with respect to quality measures within the final measure set approved under paragraph (4)(F) for the applicable performance period and the peer cohort of such provider.

“(c) GENERAL PROVISIONS APPLICABLE TO ADOPTION OF ALL MEASURES.—

“(1) RANGE OF MEASURES.—In carrying out subsection (b), the Secretary shall, to the greatest extent practicable and for each peer cohort, \[select\] a sufficient number of quality measures for potential inclusion of such measures \[in measure sets under paragraph (4)].

“(2) ANNUAL REVIEW AND UPDATES.—

“(A) IN GENERAL.—The Secretary shall review—
“(i) the quality measures selected under subsection (b)(4) for inclusion in final quality measure sets under sub-paragraph (F) of such subsection for each year such measures are to be applied under subsection (e) to ensure that such measures continue to meet the conditions applicable to such measures for such selection; and

“(ii) the final quality measures sets approved under subsection (b)(4)(F) for each year such set is 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.

“(B) INPUT FROM STAKEHOLDERS.—For purposes of conducting the review under sub-paragraph (A), the Secretary shall request medical specialty organizations and other relevant stakeholders to, as needed, identify and submit to the Secretary updates to quality measures selected under subsection (b)(4) as well as any additional quality measures. The Secretary shall [_____] review submissions under this sub-paragraph.
“(C) UPDATES.—Based on the review conducted under this paragraph for a year, the Secretary shall as needed—

“(i) select additional, and updates to, quality measures under subsection (b) for potential inclusion in final quality measure sets under paragraph (4)(F) of such subsection in the same manner as the Secretary selects such quality measures under such subsection; and

“(ii) modify final quality measure sets approved under subsection (b)(4)(F) in the same manner as the Secretary approves such sets under such subsection.

In the case of a modification under clause (ii) that removes a quality measure from a final quality measure set, such modification shall not apply under this subsection unless notification of such modification is made available to all applicable fee schedule providers.

“(3) COORDINATION WITH EXISTING PROGRAMS.—The Secretary shall, as appropriate, coordinate the selection of quality measures under subsection (b) with existing measures and requirements, such as the development of the Physician Compare
Website under section 1848(m)(5)(G). To the extent feasible, such measures should align with measures used under similar incentive programs of other payers and with measures in use under other provisions of section 1848. The Secretary shall explore options for combining performance data from incentive programs with similar commercial payer data to develop a more comprehensive picture of fee schedule provider performance that can be shared with consumers and providers to improve performance.

“(4) Adoption of additional measures.—

[Is this needed? If so, why?] The Secretary shall—

“(A) determine whether or not to select additional or updates to quality measures under paragraph (2)(C)(i); and

“(B) make determinations as to the need to approve modifications under paragraph (2)(C)(ii).

“(d) Assessing performance with respect to final quality 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 [the first year after the period of stability], to assess the performance of a fee schedule provider with respect to each quality measure included within the [final quality measure set approved under subsection (b)(4)(F) applicable for the performance period established under paragraph (3) for such year to the peer cohort in which the provider self-identified under subsection (b)(1)] for such performance period and compute a composite quality score for such provider for such performance period. 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) [Review:] provide that the performance of such provider shall be assessed for a performance period established under paragraph (3) with respect to the [quality measures within the final quality 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 utili-
ization of data from registries or electronic
health records.

“(C) Weighting of Measures.—Such a
method may provide for the assignment of dif-
ferent scoring weights based on type or cat-
egory of quality measure.

“(D) Integration of Physician Qual-
ity Programs.—In establishing such methods,
the Secretary shall, as appropriate, incorporate
comprollable physician quality incentive pro-
grams, such as under subsections (k), (n), and
(p) of section 1848.

“(2) Use of Specialty Registries.—For
purposes of this subsection, the Secretary [may]/
[shall] use data from qualified clinical data reg-
istries that meet the requirements established under
section 1848(m)(3)(E).]

“(3) Performance Period.—Not later than
[____], the Secretary shall establish a period, with
respect to a year, to assess under this subsection
performance of fee schedule providers with respect
to quality measures.
“(e) Update Adjustment Taking Into Account Assessments With Respect to Quality Measures.—

“(f) Transition for New Fee Schedule Providers.—

“(1) In General.—In the case of a new fee schedule provider there shall be.

“(2) New Fee Schedule Provider Defined.—For purposes of this subsection, the term ‘new fee schedule provider’ means 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).

“(g) Feedback; Education; Reconsideration.—

“(h) Opt Out for Providers Paid Under Alternative Payment Models.—

“(1) In General.—Payment for services that are provided by a fee schedule provider under an approved Alternative Payment Model shall be made in accordance with the payment arrangement under
such model [instead of in accordance with the update incentive program]. [Beginning with 2011, the Secretary shall identify [and publish in the Federal Register?] such models applicable under this subsection for such year.]

“(2) APPROVED ALTERNATIVE PAYMENT MODEL; ALTERNATIVE PAYMENT MODEL.—For purposes of this subsection:

“(A) APPROVED ALTERNATIVE PAYMENT MODEL.—The term ‘approved Alternative Payment Model’ means an Alternative Payment Model that is developed by the Secretary under paragraph (3) or proposed by an entity and approved by the Secretary under paragraph (4).

“(B) ALTERNATIVE PAYMENT MODEL.—The term ‘Alternative Payment Model’ or ‘APM’ means a mechanism by which payment under this title is made to a [fee schedule provider?] for most or all of the items and services furnished by such provider. Such a mechanism shall have appropriate protections to assure that changes in care associated with the application of the APM will not reduce the quality or access to care for individuals enrolled under
this part. Such a mechanism may include, but
not be limited to, any of the following:

“(i) Accountable Care Organizations.

“(ii) Medical Homes.

“(iii) Bundled payments.

“(3) Development by Secretary of Alternative Payment Models.—The Secretary shall de-
velop [and annually review and update?] Alternative Payment Models to be applied under this subsection.

“(4) Approval of Proposed Alternative Payment Models.—The Secretary shall develop a process by which physicians, medical societies, health care provider organizations, and other entities may propose Alternative Payment Models for consideration [for approval by the Secretary to apply under this subsection].”.

(c) Reports on Modified PFS System and Payment System Alternatives.—

(1) Biannual Progress Reports by Secretary.—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 on the implementation of the update incentive
program under section 1848A of the Social Security Act, as added by subsection (b)(2). Each such report shall include an evaluation of such update incentive program and recommendations with respect to such program and appropriate update mechanisms.

(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 subsection (b)(2), as of such date, is successfully satisfying [performance objectives], including with respect to—

(i) the process for developing and selecting quality measures and approving quality measure sets [], including updates and modifications, under subsection[s] (b) [] and (e) of such section 1848A;

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

(iii) the adequacy of the measures and sets so selected and approved.
(B) Evaluation by GAO and MedPAC on Implementation of Phase II.—The Comptroller General 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.

(3) Secretarial Report on Payment System Alternatives.—

(A) In general.—Not later than [____], the Secretary of Health and Human Services shall submit to Congress a report that analyzes multiple options for alternative payment models [under] [to] [in lieu of] section 1848 of the Social Security Act (42 U.S.C. 1395w–4). In analyzing such models, the Secretary shall examine at least the following models:

(i) Accountable care organization payment models.

(ii) Primary care medical home payment models.

(iii) Bundled or episodic payments for certain conditions and services.
(iv) Gainsharing arrangements.

(B) 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.

(4) Tracking expenditure growth and access.—Beginning in [____], the Secretary shall track expenditure growth and beneficiary access to physicians’ services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) and shall post on the public Internet website of the Centers for Medicare & Medicaid Services annual reports on such topics.