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TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Provisions Relating to Title I

SEC. 10101. AMENDMENTS TO SUBTITLE A [AMENDMENTS FULLY INCORPORATED ABOVE].

(a) **[Replaced section 2711 of the Public Health Service Act, as added by section 1001(5)]**

(b) **[Struck and inserted language in section 2715(a) of the Public Health Service Act, as added by section 1001(5)]**

(c) **[Inserted a new section 2715A into subpart II of part A of title XXVII of the Public Health Service Act, as added by section 1001(5)]**

(d) **[Replaced section 2716 of the Public Health Service Act, as added by section 1001(5)]**

(e) **[Amended section 2717 of the Public Health Service Act, as added by section 1001(5), by redesignating subsections (c) and (d) and inserting a new subsection (c)]**

(f) **[Replaced section 2718 of the Public Health Service Act, as added by section 1001(5)]**

(g) **[Replaced section 2719 of the Public Health Service Act, as added by section 1001(4)]**

(h) **[Inserted a new section 2719A into subpart II of part A of title XXVII of the Public Health Service Act, as added by section 1001(5)]**

(i) **[Added a subparagraph (C) to subsection (c)(1) and a new subsection (d) to section 2794 of the Public Health Service Act, as added by section 1003]**

SEC. 10102. AMENDMENTS TO SUBTITLE B [AMENDMENTS FULLY INCORPORATED ABOVE].

(a) **[Amended section 1102(a)(2)(B)]**

(b) **[Amended section 1103(a), including rewriting paragraph (2) of such section]**

SEC. 10103. AMENDMENTS TO SUBTITLE C [AMENDMENTS FULLY INCORPORATED ABOVE].

(a) **[Made an insertion into section 2701(a)(5) of the Public Health Service Act, as added by section 1201(4)]**

(b) **[Struck language in section 2708 of the Public Health Service Act, as added by section 1201(4)]**

(c) **[Added a section 2709 into subpart I of part A of title XXVII of the Public Health Service Act, as added by section 1201(4)]**

(d) **[Amended section 1251(a) in paragraph (2) and by adding a new paragraph (3); further amended by section 2301(a) of HCERA by adding an additional paragraph (4)]**

(e) **[Inserted additional matter into section 1253]**

(f) **[Redesignated section 1253 of subtitle C of title I as section 1255 and inserted a new sections 1253 (relating to annual report on self-insured plans) and 1254 (relating to study of large group market)]**

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“(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

“(ii) permit such beneficiaries to opt-out of enrollment in such program.”.

(b) **RULE OF CONSTRUCTION.**—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

SEC. 10329. DEVELOPING METHODOLOGY TO ASSESS HEALTH PLAN VALUE.

(a) **DEVELOPMENT.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), in consultation with relevant stakeholders including health insurance issuers, health care consumers, employers, health care providers, and other entities determined appropriate by the Secretary, shall develop a methodology to measure health plan value. Such methodology shall take into consideration, where applicable—

- (1) the overall cost to enrollees under the plan;
- (2) the quality of the care provided for under the plan;
- (3) the efficiency of the plan in providing care;
- (4) the relative risk of the plan’s enrollees as compared to other plans;
- (5) the actuarial value or other comparative measure of the benefits covered under the plan; and
- (6) other factors determined relevant by the Secretary.

(b) **REPORT.**—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning the methodology developed under subsection (a).

SEC. 10330. MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE DELIVERY.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan (and detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services (in this section referred to as “CMS”).

(b) **CONSIDERATIONS.**—In developing the plan, the Secretary shall consider how such modernized computer system could—

- (1) in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, make available data in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to beneficiaries of CMS programs; and
- (2) support consistent evaluations of payment and delivery system reforms under CMS programs.

(c) **POSTING OF PLAN.**—By not later than 9 months after the date of the enactment of this Act, the Secretary shall post on

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“(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

“(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

“(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

“(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than \$1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

“(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

“(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

“(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

“(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

“SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

“*[As added by section 10101(c)]* A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary

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and the State insurance commissioner, and make such information available to the public.

“SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.

【Replaced by section 10101(d)】

“(a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

“(b) RULES AND DEFINITIONS.—For purposes of this section—

“(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

“(2) HIGHLY COMPENSATED INDIVIDUAL.—The term ‘highly compensated individual’ has the meaning given such term by section 105(h)(5) of such Code.

“SEC. 2717. ENSURING THE QUALITY OF CARE.

“(a) QUALITY REPORTING.—

“(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

“(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

“(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

“(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

“(D) implement wellness and health promotion activities.

“(2) REPORTING REQUIREMENTS.—

“(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

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- (8) market conduct;
- (9) prompt payment;
- (10) appeals and grievances;
- (11) privacy and confidentiality;
- (12) licensure; and
- (13) benefit plan material or information.

PART 4—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PRO- GRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax

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credits and cost-sharing reductions allowable with respect to either plan.

(b) **STANDARD HEALTH PLAN.**—In this section, the term “standard health plan” means a health benefits plan that the State contracts with under this section—

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 1302(b); and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) **CONTRACTING PROCESS.**—

(1) **IN GENERAL.**—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) **SPECIFIC ITEMS TO BE CONSIDERED.**—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) **INNOVATION.**—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

(ii) incentives for use of preventive services; and

(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

(B) **HEALTH AND RESOURCE DIFFERENCES.**—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) **MANAGED CARE.**—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) **PERFORMANCE MEASURES.**—Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) **ENHANCED AVAILABILITY.**—

(A) **MULTIPLE PLANS.**—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

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(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) TRANSFER OF FUNDS TO STATES.—

(1) IN GENERAL.—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

(2) USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—*As revised by section 10104(o)(1)* The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 95 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.

(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the

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enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.

(iii) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) CORRECTIONS.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) ELIGIBLE INDIVIDUAL.—

(1) IN GENERAL.—In this section, the term “eligible individual” means, with respect to any State, an individual—

(A) who is a resident of the State who is not eligible to enroll in the State’s medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) **[As revised by section 10104(o)(2)]** whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved, or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

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(f) SECRETARIAL OVERSIGHT.—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

- (1) eligibility verification requirements for participation in the program;
- (2) the requirements for use of Federal funds received by the program; and
- (3) the quality and performance standards under this section.

(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.

(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—

- (A) be filed at such time and in such manner as the Secretary may require;
- (B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established

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(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))), as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) REPORT.—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) DUAL ELIGIBLE DEFINED.—In this section, the term “dual eligible individual” means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Subtitle I—Improving the Quality of Medicaid for Patients and Providers

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by inserting after section 1139A the following new section:

“SEC. 1139B. ADULT HEALTH QUALITY MEASURES.

“(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

“(b) DEADLINES.—

“(1) RECOMMENDED MEASURES.—Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

“(2) DISSEMINATION.—Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

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“(3) STANDARDIZED REPORTING.—Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

“(4) REPORTS TO CONGRESS.—Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

“(5) ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.—

“(A) IN GENERAL.—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)

“(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

“(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

“(d) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID.—

“(1) ANNUAL STATE REPORTS.—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required under section 1139A(c)), to the Secretary on the—

“(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

“(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

“(2) PUBLICATION.—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

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“(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, \$60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.”.

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) HEALTH CARE-ACQUIRED CONDITION.—In this section, the term “health care-acquired condition” means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) MEDICARE PROVISIONS.—In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

“SEC. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

“(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual’s health home for purposes of providing the individual with health home services.

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participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.”

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking “and” at the end; and

(2) by adding at the end the following:

“(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and”.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART 1—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

“(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

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“(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

“(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

“(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term ‘hospital’ means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

“(ii) EXCLUSIONS.—The term ‘hospital’ shall not include, with respect to a fiscal year, a hospital—

“(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

“(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

“(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

“(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

“(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

“(iv) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

“(2) MEASURES.—

“(A) IN GENERAL.—The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii). **[As revised by section 10335]**

“(B) REQUIREMENTS.—

“(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

“(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

“(aa) Acute myocardial infarction (AMI).

“(bb) Heart failure.

“(cc) Pneumonia.

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“(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as ‘Surgical Infection Prevention’ for discharges occurring before July 2006).

“(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

“(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

“(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of ‘Medicare spending per beneficiary’. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

“(C) LIMITATIONS.—

“(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

“(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

“(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

“(3) PERFORMANCE STANDARDS.—

“(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

“(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

“(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

“(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to

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measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

“(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

“(ii) historical performance standards;

“(iii) improvement rates; and

“(iv) the opportunity for continued improvement.

“(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

“(5) HOSPITAL PERFORMANCE SCORE.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ‘hospital performance score’) for each hospital for each performance period.

“(B) APPLICATION.—

“(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

“(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

“(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

“(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

“(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

“(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined

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after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

“(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

“(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

“(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

“(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

“(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

“(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

“(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

“(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

“(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

“(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

“(B) ADJUSTMENT TO PAYMENTS.—

“(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

“(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

“(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term ‘applicable percent’ means—

“(i) with respect to fiscal year 2013, 1.0 percent;

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“(ii) with respect to fiscal year 2014, 1.25 percent;

“(iii) with respect to fiscal year 2015, 1.5 percent;

“(iv) with respect to fiscal year 2016, 1.75 percent;

and

“(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

“(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

“(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

“(I) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

“(II) any portion of such payment amount that is attributable to—

“(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

“(bb) such other payments under subsection (d) determined appropriate by the Secretary.

“(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

“(I) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

“(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term ‘base operating DRG payment amount’ means the payment amount under such section.

“(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

“(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

“(10) PUBLIC REPORTING.—

“(A) HOSPITAL SPECIFIC INFORMATION.—

“(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

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“(I) the performance of the hospital with respect to each measure that applies to the hospital;

“(II) the performance of the hospital with respect to each condition or procedure; and

“(III) the hospital performance score assessing the total performance of the hospital.

“(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

“(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

“(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

“(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

“(11) IMPLEMENTATION.—

“(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital’s performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

“(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

“(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

“(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

“(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

“(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

“(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

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“(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

“(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).”.

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: “The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).”;

(B) in subclause (V), by striking “beginning with fiscal year 2008” and inserting “for fiscal years 2008 through 2012”;

(C) in subclause (VII), in the first sentence, by striking “data submitted” and inserting “information regarding measures submitted”; and

(D) by adding at the end the following new subclauses:

“(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

“(IX)(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

“(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

“(aa) physicians under section 1848(k); and

“(bb) other providers of services and suppliers under this title.

“(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.”.

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended

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by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

“(x)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

“(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.”.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improvement in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) REPORTS.—

(i) INTERIM REPORT.—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under

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section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—
(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the

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Secretary would have paid if the demonstration program under this section was not implemented.

(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term “applicable hospital” means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) BUDGET NEUTRALITY REQUIREMENT.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

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(D) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) EXTENSION.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause

(i), by striking “2010” and inserting “2014”; and

(B) in subparagraph (B)—

(i) in clause (i), by striking “and” at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

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

“(iii) for 2011, 1.0 percent; and

“(iv) for 2012, 2013, and 2014, 0.5 percent.”;

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause

(i), by inserting “(or, for purposes of subsection (a)(8), for the quality reporting period for the year)” after “reporting period”; and

(B) in subparagraph (C)(i), by inserting “, or, for purposes of subsection (a)(8), for a quality reporting period for the year” after “(a)(5), for a reporting period for a year”;

(3) in paragraph (5)(E)(iv), by striking “subsection (a)(5)(A)” and inserting “paragraphs (5)(A) and (8)(A) of subsection (a)”; and

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking “, 2009, 2010, and 2011” and inserting “and subsequent years”; and

(B) in clause (iii)—

(i) by inserting “(a)(8)” after “(a)(5)”; and

(ii) by striking “under subparagraph (D)(iii) of such subsection” and inserting “under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively”.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

“(8) INCENTIVES FOR QUALITY REPORTING.—

“(A) ADJUSTMENT.—

“(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on

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quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

“(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term ‘applicable percent’ means—

“(I) for 2015, 98.5 percent; and

“(II) for 2016 and each subsequent year, 98 percent.

“(B) APPLICATION.—

“(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

“(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

“(C) DEFINITIONS.—For purposes of this paragraph:

“(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms ‘eligible professional’ and ‘covered professional services’ have the meanings given such terms in subsection (k)(3).

“(ii) PHYSICIAN REPORTING SYSTEM.—The term ‘physician reporting system’ means the system established under subsection (k).

“(iii) QUALITY REPORTING PERIOD.—The term ‘quality reporting period’ means, with respect to a year, a period specified by the Secretary.”

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w-4(k)(4)) is amended by inserting “or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry” after “Database”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(3) AUTHORITY.—For years after 2014, if the Secretary of Health and Human Services determines it to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w-4(p)(2)). **[As added by section 10327(b)]**

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended by adding at the end the following new paragraph:

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“(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

“(A) The selection of measures, the reporting of which would both demonstrate—

“(i) meaningful use of an electronic health record for purposes of subsection (o); and

“(ii) quality of care furnished to an individual.

“(B) Such other activities as specified by the Secretary.”.

【Section 10327(a), p. 826, also added a paragraph (7) to section 1848(m) adding an additional incentive payment relating to physician quality reporting】

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by adding at the end the following new subparagraph:

“(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.”.

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking “There shall” and inserting “Except as provided in subparagraph (I), there shall”; and

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

“(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.”.

【Section 10331, p. 830, also provides for public reporting of performance information for eligible professionals who participate in the Physician Quality Reporting Initiative】

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w-4(n)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking “GENERAL.—The Secretary” and inserting “GENERAL.—

“(i) ESTABLISHMENT.—The Secretary”;

(ii) in clause (i), as added by clause (i), by striking “the ‘Program’” and all that follows through the period at the end of the second sentence and inserting “the ‘Program’.”; and

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

“(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups

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of physicians) that measure the resources involved in furnishing care to individuals under this title.

“(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.”; and

(B) in subparagraph (B), by striking “subparagraph (A)” and inserting “subparagraph (A)(ii)”;

(2) in paragraph (4)—

(A) in the heading, by inserting “INITIAL” after “FOCUS”; and

(B) in the matter preceding subparagraph (A), by inserting “initial” after “focus the”;

(3) in paragraph (6), by adding at the end the following new sentence: “For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.”; and

(4) by adding at the end the following new paragraphs: “(9) REPORTS ON UTILIZATION.—

“(A) DEVELOPMENT OF EPISODE GROUPEUR.—

“(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

“(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

“(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

“(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

“(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

“(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

“(i) attribute episodes of care, in whole or in part, to physicians;

“(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

“(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

“(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

“(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

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“(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

“(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

“(i) the methodologies established under subparagraph (C);

“(ii) information regarding any adjustments made to data under subparagraph (D); and

“(iii) aggregate reports with respect to physicians.

“(F) DEFINITION OF PHYSICIAN.—In this paragraph:

“(i) IN GENERAL.—The term ‘physician’ has the meaning given that term in section 1861(r)(1).

“(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

“(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

“(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.”.

(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

“(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.”.

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

“(5) QUALITY REPORTING.—

“(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

“(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

“(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1)

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for a rate year being less than such payment rates for the preceding rate year.

“(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

“(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

“(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.”

(b) INPATIENT REHABILITATION HOSPITALS.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(1) by redesignating paragraph (7) as paragraph (8); and

(2) by inserting after paragraph (6) the following new paragraph:

“(7) QUALITY REPORTING.—

“(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

“(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary

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shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

“(ii) SPECIAL RULE.—The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

“(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

“(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

“(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.”

(c) HOSPICE PROGRAMS.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

- (1) by redesignating paragraph (5) as paragraph (6); and
- (2) by inserting after paragraph (4) the following new paragraph:

graph:

“(5) QUALITY REPORTING.—

“(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

“(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice

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program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

“(ii) SPECIAL RULE.—The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

“(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

“(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(D) QUALITY MEASURES.—

“(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

“(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

“(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.”

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SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (U), by striking “and” at the end;

(B) in subparagraph (V), by striking the period at the end and inserting “, and”; and

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

“(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k).”; and

(2) by adding at the end the following new subsection:

“(k) QUALITY REPORTING BY CANCER HOSPITALS.—

“(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

“(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

“(3) QUALITY MEASURES.—

“(A) IN GENERAL.—Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

“(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

“(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

“(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients’ perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.”.

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SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities. **[As revised by section 10301(b)]**

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) HOME HEALTH AGENCIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

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(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

【Section 10301 added a new subsection (f) at the end. There are no subsections (c)-(e)】

(f) AMBULATORY SURGICAL CENTERS.—*【As added by section 10301(a)】*

(1) IN GENERAL.—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A of such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in ambulatory surgical centers.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

(E) Any other issues determined appropriate by the Secretary.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) REPORT TO CONGRESS.—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

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SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

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

(1) in subsection (b)(1), by inserting “subject to subsection (p),” after “1998,”; and

(2) by adding at the end the following new subsection:

“(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

“(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

“(2) QUALITY.—

“(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

“(B) MEASURES.—

“(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

“(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

“(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

“(4) IMPLEMENTATION.—

“(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

“(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

“(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

“(iii) The initial performance period (as specified under subparagraph (B)(ii)).

“(B) DEADLINES FOR IMPLEMENTATION.—

“(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary

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shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

“(ii) INITIAL PERFORMANCE PERIOD.—

“(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

“(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

“(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished—

“(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

“(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

“(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

“(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

“(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

“(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term ‘physician’ has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

“(8) DEFINITIONS.—For purposes of this subsection:

“(A) COSTS.—The term ‘costs’ means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

“(B) PERFORMANCE PERIOD.—The term ‘performance period’ means a period specified by the Secretary.

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“(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

“(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(A) the establishment of the value-based payment modifier under this subsection;

“(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

“(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

“(D) the dates for implementation of the value-based payment modifier;

“(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

“(F) the application of the value-based payment modifier under paragraph (7); and

“(G) the determination of costs under paragraph (8)(A).”.

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

“(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

“(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

“(2) APPLICABLE HOSPITALS.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘applicable hospital’ means a subsection (d) hospital that meets the criteria described in subparagraph (B).

“(B) CRITERIA DESCRIBED.—

“(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

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“(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

“(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

“(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term ‘hospital acquired condition’ means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

“(4) APPLICABLE PERIOD.—In this subsection, the term ‘applicable period’ means, with respect to a fiscal year, a period specified by the Secretary.

“(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

“(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

“(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

“(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

“(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) The criteria described in paragraph (2)(A).

“(B) The specification of hospital acquired conditions under paragraph (3).

“(C) The specification of the applicable period under paragraph (4).

“(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6).”.

(b) STUDY AND REPORT ON EXPANSION OF HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER PROVIDERS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on expanding the healthcare acquired conditions policy under subsection (d)(4)(D) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under

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title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, long-term care hospitals (as described in subsection(d)(1)(B)(iv) of such section), hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) REPORT.—Not later than January 1, 2012, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART 2—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

“PART S—HEALTH CARE QUALITY PROGRAMS

“Subpart I—National Strategy for Quality Improvement in Health Care

“SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

“(a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

“(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

“(2) IDENTIFICATION OF PRIORITIES.—

“(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

“(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

“(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;

“(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

“(iii) address gaps in quality, efficiency, comparative effectiveness information (taking into consideration the limitations set forth in subsections (c) and (d) of section 1182 of the Social Security Act), and health outcomes measures and data aggregation techniques; **[As revised by section 10302]**

“(iv) improve Federal payment policy to emphasize quality and efficiency;

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“(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

“(vi) address the health care provided to patients with high-cost chronic diseases;

“(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

“(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

“(ix) address other areas as determined appropriate by the Secretary.

“(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.

“(D) COORDINATION WITH STATE AGENCIES.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children’s Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under subparagraph (A).

“(b) STRATEGIC PLAN.—

“(1) IN GENERAL.—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

“(2) REQUIREMENTS.—The strategic plan shall include provisions for addressing, at a minimum, the following:

“(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

“(B) Agency-specific strategic plans to achieve national priorities.

“(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

“(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

“(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

“(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

“(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

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“(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.—

“(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

“(2) UPDATES.—

“(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

“(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

“(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

“(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

“(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

“(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

“(C) SATISFACTION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

“(e) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

“(1) the national priorities for health care quality improvement established under subsection (a)(2);

“(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

“(3) other information, as the Secretary determines to be appropriate.”.

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the “Working Group”).

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

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(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

- (A) the Department of Health and Human Services;
- (B) the Centers for Medicare & Medicaid Services;
- (C) the National Institutes of Health;
- (D) the Centers for Disease Control and Prevention;
- (E) the Food and Drug Administration;
- (F) the Health Resources and Services Administration;
- (G) the Agency for Healthcare Research and Quality;
- (H) the Office of the National Coordinator for Health Information Technology;
- (I) the Substance Abuse and Mental Health Services Administration;
- (J) the Administration for Children and Families;
- (K) the Department of Commerce;
- (L) the Office of Management and Budget;
- (M) the United States Coast Guard;
- (N) the Federal Bureau of Prisons;
- (O) the National Highway Traffic Safety Administration;
- (P) the Federal Trade Commission;
- (Q) the Social Security Administration;
- (R) the Department of Labor;
- (S) the United States Office of Personnel Management;
- (T) the Department of Defense;
- (U) the Department of Education;
- (V) the Department of Veterans Affairs;
- (W) the Veterans Health Administration; and
- (X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE-CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. QUALITY MEASURE DEVELOPMENT.

(a) PUBLIC HEALTH SERVICE ACT.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

- (1) by redesignating part D as part E;
- (2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;
- (3) in section 948(1), as so redesignated, by striking “931” and inserting “941”; and
- (4) by inserting after section 926 the following:

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“PART D—HEALTH CARE QUALITY IMPROVEMENT

“Subpart I—Quality Measure Development

“SEC. 931. QUALITY MEASURE DEVELOPMENT.

“(a) **QUALITY MEASURE.**—In this subpart, the term ‘quality measure’ means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

“(b) **IDENTIFICATION OF QUALITY MEASURES.**—

“(1) **IDENTIFICATION.**—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

“(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

“(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act; and

“(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

“(2) **PUBLICATION.**—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

“(c) **GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.**—

“(1) **IN GENERAL.**—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

“(2) **PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.**—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

“(A) health outcomes and functional status of patients;

“(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

“(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 936);

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“(D) the meaningful use of health information technology;

“(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

“(F) the efficiency of care;

“(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

“(H) patient experience and satisfaction;

“(I) the use of innovative strategies and methodologies identified under section 933; and

“(J) other areas determined appropriate by the Secretary.

“(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

“(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

“(B) have adopted procedures to include in the quality measure development process—

“(i) the views of those providers or payers whose performance will be assessed by the measure; and

“(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

“(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

“(D) have transparent policies regarding governance and conflicts of interest; and

“(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

“(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

“(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

“(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

“(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

“(D) Each quality measure is free of charge to users of such measure.

“(E) Each quality measure is publicly available on an Internet website.

“(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract

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under section 1890(a) of the Social Security Act or adopted by the Secretary.

“(e) COORDINATION OF GRANTS.—The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5) and 1139B(4)(A) of the Social Security Act.

“(f) DEVELOPMENT OF OUTCOME MEASURES.—**[As added by section 10303(a)]**

“(1) IN GENERAL.—The Secretary shall develop, and periodically update (not less than every 3 years), provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.

“(2) CATEGORIES OF MEASURES.—The measures developed under this subsection shall include, to the extent determined appropriate by the Secretary—

“(A) outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive acute and chronic medical conditions; and

“(B) outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, or infirm elderly individuals).

“(3) GOALS.—In developing such measures, the Secretary shall seek to—

“(A) address issues regarding risk adjustment, accountability, and sample size;

“(B) include the full scope of services that comprise a cycle of care; and

“(C) include multiple dimensions.

“(4) TIMEFRAME.—

“(A) ACUTE AND CHRONIC DISEASES.—Not later than 24 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(A).

“(B) PRIMARY AND PREVENTIVE CARE.—Not later than 36 months after the date of enactment of this Act, the Secretary shall develop not less than 10 measures described in paragraph (2)(B).”

(b) SOCIAL SECURITY ACT.—Section 1890A of the Social Security Act, as added by section 3014(b), is amended by adding at the end the following new subsection: **[Note: amendment made by section 10304 strikes “quality” and inserts “quality and efficiency” in section 1890A of the Social Security Act but did not specifically amend headings below (which have different typeface)]**

“(e) DEVELOPMENT OF **QUALITY AND EFFICIENCY** MEASURES.—The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality and efficiency measures (as determined appropriate by the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.

[A subsection (f) was also added by section 10303 as shown below:]

“(f) HOSPITAL ACQUIRED CONDITIONS.—The Secretary shall, to the extent practicable, publicly report on measures for hospital-

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acquired conditions that are currently utilized by the Centers for Medicare & Medicaid Services for the adjustment of the amount of payment to hospitals based on rates of hospital-acquired infections.”.

(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, \$75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs: *[amendment by section 10304 strikes “quality” and inserts “quality and efficiency” in new paragraph (7) but did not specifically amend heading of paragraph (7)(B) below (which has different typeface).]*

“(7) CONVENING MULTI-STAKEHOLDER GROUPS.—

“(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

“(i) the selection of quality and efficiency measures described in subparagraph (B), from among—

“(I) such measures that have been endorsed by the entity; and

“(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and

“(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

“(B) QUALITY *and efficiency* measures.—

“(i) IN GENERAL.—Subject to clause (ii), the quality and efficiency measures described in this subparagraph are quality and efficiency measures—

“(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), 1886(s)(4)(D), and 1895(b)(3)(B)(v); *[As revised by section 10322(b)]*

“(II) for use in reporting performance information to the public; and

“(III) for use in health care programs other than for use under this Act.

“(ii) EXCLUSION.—Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing

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facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality and efficiency measures described in this subparagraph.

“(C) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

“(i) IN GENERAL.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality and efficiency measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

“(ii) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

“(D) MULTI-STAKEHOLDER GROUP DEFINED.—In this paragraph, the term ‘multi-stakeholder group’ means, with respect to a quality and efficiency measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality and efficiency measure.

“(8) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7).”.

(2) ANNUAL REPORT.—Section 1890(b)(5)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(5)(A)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

“(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

“(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

“(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).”.

(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following: **[amendment by section 10304 strikes “quality” and inserts “quality and efficiency” in new section but did not specifically amend headings below (which have different typefaces).]**

“QUALITY *and efficiency* MEASUREMENT

“SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY **AND EFFICIENCY** MEASURES.—The Secretary shall establish a pre-rulemaking process under which the

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following steps occur with respect to the selection of quality and efficiency measures described in section 1890(b)(7)(B):

“(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures described in subparagraph (B) of such paragraph.

“(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality and efficiency measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

“(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

“(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.—The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality and efficiency measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

“(5) RATIONALE FOR USE OF QUALITY *and efficiency measures*.—The Secretary shall publish in the Federal Register the rationale for the use of any quality and efficiency measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

“(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

“(A) conduct an assessment of the quality and efficiency impact of the use of endorsed measures described in section 1890(b)(7)(B); and

“(B) make such assessment available to the public.

“(b) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

“(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality and efficiency measures used by the Secretary. Such process shall include the following:

“(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

“(B) The dissemination of such quality and efficiency measures through the national strategy developed under section 399HH of the Public Health Service Act.

“(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality and efficiency measures under the process established under paragraph (1).

“(c) REVIEW OF QUALITY *AND EFFICIENCY* MEASURES USED BY THE SECRETARY.—

“(1) IN GENERAL.—The Secretary shall—

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“(A) periodically (but in no case less often than once every 3 years) review quality and efficiency measures described in section 1890(b)(7)(B); and

“(B) with respect to each such measure, determine whether to—

“(i) maintain the use of such measure; or

“(ii) phase out such measure.

“(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

“(A) seek to avoid duplication of measures used; and

“(B) take into consideration current innovative methodologies and strategies for quality and efficiency improvement practices in the delivery of health care services that represent best practices for such quality and efficiency improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

“(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using the quality and efficiency measures identified under sections 1139A and 1139B.

【Note: A subsection (e) was also added by section 3013(b) and a subsection (f) was also added by section 10303(b) of HCERA】

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of \$20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3011, is further amended by adding at the end the following:

“SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

“(a) IN GENERAL.—*【Replaced by section 10305】*

“(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish and implement an overall strategic framework to carry out the public reporting of performance information, as described in section 399JJ. Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

“(2) COLLECTION AND AGGREGATION OF DATA.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose. The Secretary shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of health information technology systems, the interoperability of such technology systems, and related standards that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

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“(3) SCOPE.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (1) involve an increasingly broad range of patient populations, providers, and geographic areas over time.

“(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

“(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

“(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

“(A) be—

“(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

“(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

“(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

“(B) promote the use of the systems that provide data to improve and coordinate patient care;

“(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, with an opportunity for providers to correct inaccurate measures; and

“(D) agree to report, as determined by the Secretary, measures on quality and resource use to the public in accordance with the public reporting process established under section 399JJ.

“(c) CONSISTENT DATA AGGREGATION.—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

“(d) MATCHING FUNDS.—The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

“(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

“SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

“(a) DEVELOPMENT OF PERFORMANCE WEBSITES.—The Secretary shall make available to the public, through standardized Internet

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websites, performance information summarizing data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.

“(b) INFORMATION ON CONDITIONS.—The performance information made publicly available on an Internet website, as described in subsection (a), shall include information regarding clinical conditions to the extent such information is available, and the information shall, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

“(c) CONSULTATION.—

“(1) IN GENERAL.—In carrying out this section, the Secretary shall consult with the entity with a contract under section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.

“(2) CONSULTATION WITH STAKEHOLDERS.—The entity with a contract under section 1890(a) of the Social Security Act shall convene multi-stakeholder groups, as described in such section, to review the design and format of each Internet website made available under subsection (a) and shall transmit to the Secretary the views of such multi-stakeholder groups with respect to each such design and format.

“(d) COORDINATION.—Where appropriate, the Secretary shall coordinate the manner in which data are presented through Internet websites described in subsection (a) and for public reporting of other quality measures by the Secretary, including such quality measures under title XVIII of the Social Security Act.

“(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.”.

PART 3—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

“CENTER FOR MEDICARE AND MEDICAID INNOVATION

“SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

“(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the ‘CMI’) to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that

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the website of the Centers for Medicare & Medicaid Services the plan described in subsection (a).

SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) IN GENERAL.—

(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w-4).

(2) PLAN.—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) OTHER REQUIRED CONSIDERATIONS.—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such

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information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) EXPANSION.—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

(h) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

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(i) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL.—The term “eligible professional” has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(2) PHYSICIAN.—The term “physician” has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) PHYSICIAN COMPARE.—The term “Physician Compare” means the Internet website developed under subsection (a)(1).

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(e) AVAILABILITY OF MEDICARE DATA.—

“(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

“(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

“(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

“(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

“(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

“(4) REQUIREMENTS.—

“(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

“(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

“(ii) (I) except as provided in subclause (II), if available, use standard measures, such as measures

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the website of the Centers for Medicare & Medicaid Services the plan described in subsection (a).

SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) **IN GENERAL.**—

(1) **DEVELOPMENT.**—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w-4).

(2) **PLAN.**—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) **OTHER REQUIRED CONSIDERATIONS.**—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such

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information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) EXPANSION.—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

(h) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

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(i) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL.—The term “eligible professional” has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(2) PHYSICIAN.—The term “physician” has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) PHYSICIAN COMPARE.—The term “Physician Compare” means the Internet website developed under subsection (a)(1).

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(e) AVAILABILITY OF MEDICARE DATA.—

“(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

“(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

“(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

“(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

“(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

“(4) REQUIREMENTS.—

“(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

“(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

“(ii) (I) except as provided in subclause (II), if available, use standard measures, such as measures

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Subtitle F—Health Care Quality Improvements

**SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY
IMPROVEMENT TECHNICAL ASSISTANCE.**

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

“Subpart II—Health Care Quality Improvement Programs

“SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

“(a) PURPOSE.—The purposes of this section are to—

“(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value; and

“(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

“(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), or any other relevant agency or department designated by the Director, shall—

“(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

“(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

“(A) best practices for quality improvement practices in the delivery of health care services; and

“(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

“(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

“(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

“(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

“(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

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“(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

“(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

“(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

“(8) provide for the development of best practices in the delivery of health care services that—

“(A) have a high likelihood of success, based on structured review of empirical evidence;

“(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

“(C) are designed to be readily adapted by health care providers in a variety of settings; and

“(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

“(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children’s health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

“(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

“(c) RESEARCH FUNCTIONS OF CENTER.—

“(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

“(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

“(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

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“(B) identify areas in which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1890(a) of the Social Security Act in the report required under section 399JJ;

“(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

“(D) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

“(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

“(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

“(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

“(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Enterococcus infections and other emerging infections; and

“(iii) practical methods for reducing preventable hospital admissions and readmissions;

“(G) expand demonstration projects for improving the quality of children’s health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

“(H) identify and mitigate hazards by—

“(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

“(ii) using the results of such analyses to develop scientific methods of response to such events;

“(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

“(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

“(d) DISSEMINATION OF RESEARCH FINDINGS.—

“(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

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“(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

“(e) PRIORITIZATION.—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

“(1) the cost to Federal health programs;

“(2) consumer assessment of health care experience;

“(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

“(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children;

“(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

“(6) the evolution of meaningful use of health information technology, as defined in section 3000.

“(f) COORDINATION.—The Center shall coordinate its activities with activities conducted by the Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act.

“(g) FUNDING.—There is authorized to be appropriated to carry out this section \$20,000,000 for fiscal years 2010 through 2014.

“SEC. 934. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

“(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), shall award—

“(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

“(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

“(b) ELIGIBLE ENTITIES.—

“(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

“(A) may be a health care provider, health care provider association, professional society, health care worker

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organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399V-1, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and **[As revised by section 10501(f)(2)]**

“(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

“(2) IMPLEMENTATION AWARD.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

“(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

“(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

“(c) APPLICATION.—

“(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

“(A) a plan for a sustainable business model that may include a system of—

“(i) charging fees to institutions and providers that receive technical support from the entity; and

“(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

“(B) such other information as the Director may require.

“(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

“(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

“(i) financial cost, staffing requirements, and timeline for implementation; and

“(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

“(B) such other information as the Director may require.

“(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$1 for each \$5 of Federal funds provided under the grant or contract. Such non-Federal matching funds

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may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

“(e) EVALUATION.—

“(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

“(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 933;

“(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

“(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

“(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

“(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399V–1 regarding the dissemination of quality improvement, system delivery reform, and best practices information. *[As revised by section 10501(f)(2)]*”.

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

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(d) **AUTHORITY.**—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) **CLARIFICATION.**—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) **IN GENERAL.**—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) **ELIGIBILITY.**—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection

(c).

(c) **MATCHING FUNDS.**—

(1) **IN GENERAL.**—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than \$1 for each \$5 of Federal funds provided under the grant.

(2) **DETERMINATION OF AMOUNT CONTRIBUTED.**—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

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(d) **EVALUATION.**—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) **REPORTS.**—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN'S HEALTH.

(a) **HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.**—

(1) **ESTABLISHMENT.**—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

“SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

“(a) **ESTABLISHMENT OF OFFICE.**—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the ‘Office’). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

“(b) **DUTIES.**—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

“(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

“(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

“(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

“(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

“(5) establish a National Women's Health Information Center to—

“(A) facilitate the exchange of information regarding matters relating to health information, health promotion,

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“(1) not less than \$95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

“(2) not less than \$60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

“(3) not less than \$32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).”.

SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as “the Conference”).

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

“SEC. 409J. PAIN RESEARCH.

“(a) RESEARCH INITIATIVES.—

“(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

“(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations

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on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

“(3) DEFINITION.—In this subsection, the term ‘Pain Consortium’ means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

“(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

“(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the ‘Committee’), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

“(2) MEMBERSHIP.—

“(A) IN GENERAL.—The Committee shall be composed of the following voting members:

“(i) Not more than 7 voting Federal representatives appoint by the Secretary from agencies that conduct pain care research and treatment.

“(ii) 12 additional voting members appointed under subparagraph (B).

“(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

“(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

“(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

“(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

“(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

“(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

“(5) DUTIES.—The Committee shall—

“(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

“(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

“(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

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“(D) make recommendations on how best to disseminate information on pain care; and

“(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

“(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.”

(c) PAIN CARE EDUCATION AND TRAINING.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

“SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

“(a) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

“(b) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on—

“(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

“(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

“(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

“(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

“(5) recent findings, developments, and improvements in the provision of pain care.

“(c) EVALUATION OF PROGRAMS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

“(d) PAIN CARE DEFINED.—For purposes of this section the term ‘pain care’ means the assessment, diagnosis, treatment, or management of acute or chronic pain regardless of causation or body location.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this subsection shall remain available until expended.”

SEC. 4306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b-9a(e)(8)) is amended to read as follows:

“(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out

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or the date that is 90 days after the date of the imposition of the penalty;

“(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

“(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

“(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).”.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting “(ii)(IV),” after “(i),”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

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(b) **REQUIREMENTS.**—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the “Special Focus Facility” program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) **RESPONSIBILITIES.**—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) **IMPLEMENTATION OF RECOMMENDATIONS.**—

(1) **RECEIPT OF FINDING BY CHAIN.**—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) **RECEIPT OF REPORT BY INDEPENDENT MONITOR.**—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) **COST OF APPOINTMENT.**—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the demonstration project under this section.

(g) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) **DEFINITIONS.**—In this section:

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(1) **ADDITIONAL DISCLOSABLE PARTY.**—The term “additional disclosable party” has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) **FACILITY.**—The term “facility” means a skilled nursing facility or a nursing facility.

(3) **NURSING FACILITY.**—The term “nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) **SKILLED NURSING FACILITY.**—The term “skilled nursing facility” has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) **EVALUATION AND REPORT.**—

(1) **EVALUATION.**—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

(2) **REPORT.**—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.

(a) **IN GENERAL.**—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

“(h) **NOTIFICATION OF FACILITY CLOSURE.**—

“(1) **IN GENERAL.**—Any individual who is the administrator of a facility must—

“(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

“(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

“(ii) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;

“(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

“(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be

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(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than \$3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

“PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“SEC. 1181. (a) DEFINITIONS.—In this section:

“(1) BOARD.—The term ‘Board’ means the Board of Governors established under subsection (f).

“(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

“(A) IN GENERAL.—The terms ‘comparative clinical effectiveness research’ and ‘research’ mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

“(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

“(3) CONFLICT OF INTEREST.—The term ‘conflict of interest’ means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

“(4) REAL CONFLICT OF INTEREST.—The term ‘real conflict of interest’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

“(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

“(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds \$10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock,

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or other financial benefit and the current value of the member or close relative's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

“(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

“(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the ‘Patient-Centered Outcomes Research Institute’ (referred to in this section as the ‘Institute’) which is neither an agency nor establishment of the United States Government.

“(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Non-profit Corporation Act.

“(3) FUNDING OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’) under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

“(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

“(d) DUTIES.—

“(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

“(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

“(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and

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the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

“(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

“(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

“(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

“(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

“(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

“(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

“(i) CONTRACTS.—

“(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

“(aa) Appropriate agencies and instrumentalities of the Federal Government.

“(bb) Appropriate academic research, private sector research, or study-conducting entities.

“(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

“(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

“(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

“(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

“(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

“(IV) subject to clause (iv), permit a researcher who conducts original research, as described in

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subparagraph (A)(ii), under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication, as long as the researcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate; **[As revised by section 10602(1)(A)(i) and (ii)]**

“(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

“(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

“(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

“(iii) **COVERAGE OF COPAYMENTS OR COINSURANCE.**—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

“(iv) **SUBSEQUENT USE OF THE DATA.**—The Institute shall not allow the subsequent use of data from original research in work-for-hire contracts with individuals, entities, or instrumentalities that have a financial interest in the results, unless approved under a data use agreement with the Institute. **[Replaced by section 10602(1)(B)]**

“(C) **REVIEW AND UPDATE OF EVIDENCE.**—The Institute shall review and update evidence on a periodic basis as appropriate.

“(D) **TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.**—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular sub-types, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

“(E) **DIFFERENCES IN TREATMENT MODALITIES.**—Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

“(3) **DATA COLLECTION.**—

“(A) **IN GENERAL.**—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII,

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XIX, and XXI, as well as provide access to the data networks developed under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

“(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

“(4) APPOINTING EXPERT ADVISORY PANELS.—

“(A) APPOINTMENT.—

“(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

“(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

“(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—

In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

“(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

“(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

“(6) ESTABLISHING METHODOLOGY COMMITTEE.—

“(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

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“(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

“(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

“(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

“(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

“(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

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“(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee’s performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

“(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

“(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

“(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

“(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

“(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

“(C) USE OF EXISTING PROCESSES.—

“(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

“(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

“(8) RELEASE OF RESEARCH FINDINGS.—

“(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

“(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

“(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

“(iii) include limitations of the research and what further research may be needed as appropriate;

“(iv) do not include practice guidelines, coverage recommendations, payment, or policy recommendations; and **[As revised by section 10602(2)]**

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“(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

“(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term ‘research findings’ means the results of a study or assessment.

“(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

“(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

“(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

“(B) the research project agenda and budget of the Institute for the following year;

“(C) any administrative activities conducted by the Institute during the preceding year;

“(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

“(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

“(e) ADMINISTRATION.—

“(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

“(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

“(f) BOARD OF GOVERNORS.—

“(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

“(A) The Director of Agency for Healthcare Research and Quality (or the Director’s designee).

“(B) The Director of the National Institutes of Health (or the Director’s designee).

“(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

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“(i) 3 members representing patients and health care consumers.

“(ii) 7 members representing physicians and providers, including 4 members representing physicians (at least 1 of whom is a surgeon), 1 nurse, 1 State-licensed integrative health care practitioner, and 1 representative of a hospital. **[Replaced by section 10602(3)]**

“(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

“(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

“(v) 1 member representing quality improvement or independent health service researchers.

“(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

“(2) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

“(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

“(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

“(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

“(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such

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assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

“(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

“(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

“(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

“(2) REVIEW AND ANNUAL REPORTS.—

“(A) REVIEW.—The Comptroller General of the United States shall review the following:

“(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

“(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

“(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported, and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under such section.

“(iv) Not less frequently than every 5 years, the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

“(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the Patient-Centered

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Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code of 1986 are appropriate and whether such sources of funding should be continued or adjusted.

“(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

“(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

“(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

“(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

“(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

“(A) Information contained in research findings as specified in subsection (d)(9).

“(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

“(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

“(D) Subsequent comments received during each of the public comment periods.

“(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

“(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

“(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

“(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in

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selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

“(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

“(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

“(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

“(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

“(j) RULES OF CONSTRUCTION.—

“(1) COVERAGE.—Nothing in this section shall be construed—

“(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

“(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.”.

(b) DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.—Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3606, is further amended by inserting after section 936 the following:

“SEC. 937. DISSEMINATION AND BUILDING CAPACITY FOR RESEARCH.

“(a) IN GENERAL.—

“(1) DISSEMINATION.—The Office of Communication and Knowledge Transfer (referred to in this section as the ‘Office’) at the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality), in consultation with the National Institutes of Health, shall broadly disseminate the research findings that are published by the Patient Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act (referred to in this section as the ‘Institute’) and other government-funded research relevant to comparative

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clinical effectiveness research. The Office shall create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. The Office shall also develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for profit, and academic sources.

“(2) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research to physicians, health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans. Materials, forums, and media used to disseminate the findings, informational tools, and resource databases shall—

“(A) include a description of considerations for specific subpopulations, the research methodology, and the limitations of the research, and the names of the entities, agencies, instrumentalities, and individuals who conducted any research which was published by the Institute; and

“(B) not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment.

“(b) INCORPORATION OF RESEARCH FINDINGS.—The Office, in consultation with relevant medical and clinical associations, shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

“(c) FEEDBACK.—The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided under this section.

“(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from making its research findings publicly available as required under section 1181(d)(8) of the Social Security Act.

“(e) TRAINING OF RESEARCHERS.—The Agency for Health Care Research and Quality, in consultation with the National Institutes of Health, shall build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers in the methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials. At a minimum, such training shall be in methods that meet the methodological standards adopted under section 1181(d)(9) of the Social Security Act.

“(f) BUILDING DATA FOR RESEARCH.—The Secretary shall provide for the coordination of relevant Federal health programs to build data capacity for comparative clinical effectiveness research, including the development and use of clinical registries and health outcomes research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

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“(g) AUTHORITY TO CONTRACT WITH THE INSTITUTE.—Agencies and instrumentalities of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this part, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and instrumentalities.”.

(c) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a), is amended by adding at the end the following new section:

“LIMITATIONS ON CERTAIN USES OF COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

“SEC. 1182. (a) The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

“(b) Nothing in section 1181 shall be construed as—

“(1) superceding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1862(l)(1); or

“(2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative clinical effectiveness research.

“(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill.

“(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under title XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual’s life due to the individual’s age, disability, or terminal illness.

“(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with the intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

“(2)(A) Paragraph (1) shall not be construed to—

“(i) limit the application of differential copayments under title XVIII based on factors such as cost or type of service; or

“(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual’s life due to that individual’s age, disability, or terminal illness.

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“(3) Nothing in the provisions of, or amendments made by the Patient Protection and Affordable Care Act, shall be construed to limit comparative clinical effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

“(e) The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual’s disability) as a threshold to establish what type of health care is cost effective or recommended. The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.”.

(d) IN GENERAL.—Part D of title XI of the Social Security Act, as added by subsection (a) and amended by subsection (c), is amended by adding at the end the following new section:

“TRUST FUND TRANSFERS TO PATIENT-CENTERED OUTCOMES
RESEARCH TRUST FUND

“SEC. 1183. (a) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the ‘PCORTF’) under section 9511 of the Internal Revenue Code of 1986, of the following:

“(1) For fiscal year 2013, an amount equal to \$1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

“(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to \$2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

“(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.”.

(e) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

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“SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

“(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the ‘Patient-Centered Outcomes Research Trust Fund’ (hereafter in this section referred to as the ‘PCORTF’), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

“(b) TRANSFERS TO FUND.—

“(1) APPROPRIATION.—There are hereby appropriated to the Trust Fund the following:

“(A) For fiscal year 2010, \$10,000,000.

“(B) For fiscal year 2011, \$50,000,000.

“(C) For fiscal year 2012, \$150,000,000.

“(D) For fiscal year 2013—

“(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

“(ii) \$150,000,000.

“(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

“(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

“(ii) \$150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

“(2) TRUST FUND TRANSFERS.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

“(3) LIMITATION ON TRANSFERS TO PCORTF.—No amount may be appropriated or transferred to the PCORTF on and after the date of any expenditure from the PCORTF which is not an expenditure permitted under this section. The determination of whether an expenditure is so permitted shall be made without regard to—

“(A) any provision of law which is not contained or referenced in this chapter or in a revenue Act, and

“(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of this paragraph.

“(c) TRUSTEE.—The Secretary of the Treasury shall be a trustee of the PCORTF.

“(d) EXPENDITURES FROM FUND.—

“(1) AMOUNTS AVAILABLE TO THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subject to paragraph (2), amounts in the PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act for carrying out part D of title XI of the Social Security Act (as in effect on the date of enactment of such Act).

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“(2) TRANSFER OF FUNDS.—

“(A) IN GENERAL.—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each of fiscal years 2011 through 2019 to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

“(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

“(C) REQUIREMENTS.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

“(i) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other relevant office designated by Agency for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

“(ii) 20 percent to the Secretary to carry out the activities described in such section 937.

“(e) NET REVENUES.—For purposes of this section, the term ‘net revenues’ means the amount estimated by the Secretary of the Treasury based on the excess of—

“(1) the fees received in the Treasury under subchapter B of chapter 34, over

“(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

“(f) TERMINATION.—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.”

(B) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

“Sec. 9511. Patient-centered outcomes research trust fund.”

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

“Subchapter B—Insured and Self-Insured Health Plans

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

“SEC. 4375. HEALTH INSURANCE.

“(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of \$2 (\$1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

“(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

“(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

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“(1) IN GENERAL.—Except as otherwise provided in this section, the term ‘specified health insurance policy’ means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

“(2) EXEMPTION FOR CERTAIN POLICIES.—The term ‘specified health insurance policy’ does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

“(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

“(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B), such arrangement shall be treated as a specified health insurance policy, and the person referred to in such subparagraph shall be treated as the issuer.

“(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

“(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

“(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

“SEC. 4376. SELF-INSURED HEALTH PLANS.

“(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to \$2 (\$1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

“(b) LIABILITY FOR FEE.—

“(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

“(2) PLAN SPONSOR.—For purposes of paragraph (1) the term ‘plan sponsor’ means—

“(A) the employer in the case of a plan established or maintained by a single employer,

“(B) the employee organization in the case of a plan established or maintained by an employee organization,

“(C) in the case of—

“(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

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“(ii) a multiple employer welfare arrangement, or

“(iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

“(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

“(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

“(1) any portion of such coverage is provided other than through an insurance policy, and

“(2) such plan is established or maintained—

“(A) by 1 or more employers for the benefit of their employees or former employees,

“(B) by 1 or more employee organizations for the benefit of their members or former members,

“(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

“(D) by a voluntary employees’ beneficiary association described in section 501(c)(9),

“(E) by any organization described in section 501(c)(6),

or

“(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

“(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

“(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

“SEC. 4377. DEFINITIONS AND SPECIAL RULES.

“(a) DEFINITIONS.—For purposes of this subchapter—

“(1) ACCIDENT AND HEALTH COVERAGE.—The term ‘accident and health coverage’ means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

“(2) INSURANCE POLICY.—The term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

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“(3) UNITED STATES.—The term ‘United States’ includes any possession of the United States.

“(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

“(1) IN GENERAL.—For purposes of this subchapter—

“(A) the term ‘person’ includes any governmental entity, and

“(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

“(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

“(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term ‘exempt governmental program’ means—

“(A) any insurance program established under title XVIII of the Social Security Act,

“(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

“(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans, and

“(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

“(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

“(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.”.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

“Subchapter A—Policies Issued By Foreign Insurers”.

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

(f) TAX-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subsection 501(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

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“(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.”.

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under subsection (e)(2) of such section, shall terminate on the date of enactment of this Act.

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) **MEDICARE.**—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following: “Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).”;

(2) by redesignating paragraph (2) as paragraph (8); and
【Replaced by section 10603(b)】

(3) by inserting after paragraph (1) the following:

“(2) **PROVIDER SCREENING.**—

“(A) **PROCEDURES.**—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

“(B) **LEVEL OF SCREENING.**—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

“(i) shall include a licensure check, which may include such checks across States; and

“(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

“(I) a criminal background check;

“(II) fingerprinting;

“(III) unscheduled and unannounced site visits, including preenrollment site visits;

“(IV) database checks (including such checks across States); and

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SEC. 10325. REVISION TO SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.

(a) TEMPORARY DELAY OF RUG–IV.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to October 1, 2011, implement Version 4 of the Resource Utilization Groups (in this subsection referred to as “RUG–IV”) published in the Federal Register on August 11, 2009, entitled “Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities” (74 Fed. Reg. 40288). Beginning on October 1, 2010, the Secretary of Health and Human Services shall implement the change specific to therapy furnished on a concurrent basis that is a component of RUG–IV and changes to the lookback period to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case mix classification under the skilled nursing facility prospective payment system under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(b) CONSTRUCTION.—Nothing in this section shall be interpreted as delaying the implementation of Version 3.0 of the Minimum Data Sets (MDS 3.0) beyond the planned implementation date of October 1, 2010.

SEC. 10326. PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR CERTAIN MEDICARE PROVIDERS.

(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall, for each provider described in subsection (b), conduct a separate pilot program under title XVIII of the Social Security Act to test the implementation of a value-based purchasing program for payments under such title for the provider.

(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

(2) Long-term care hospitals (as described in clause (iv) of such section).

(3) Rehabilitation hospitals (as described in clause (ii) of such section).

(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

(5) Hospice programs (as defined in section 1861(dd)(2) of such Act (42 U.S.C. 1395x(dd)(2))).

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary solely for purposes of carrying out the pilot programs under this section.

(d) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section under the separate pilot program for value based purchasing (as described in subsection (a)) for each provider type described in paragraphs (1) through (5) of subsection (b) for applicable items and services under title XVIII of the Social Security Act for a year shall be established in a manner that does not result in spending more under each such value based purchasing program for such year than would otherwise be expended for such

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provider type for such year if the pilot program were not implemented, as estimated by the Secretary.

(e) EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2018, expand the duration and scope of a pilot program conducted under this subsection, to the extent determined appropriate by the Secretary, if—

(1) the Secretary determines that such expansion is expected to—

(A) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

(B) improve the quality of care and reduce spending;

(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under such title XIII for Medicare beneficiaries.

SEC. 10327. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

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

“(7) ADDITIONAL INCENTIVE PAYMENT.—

“(A) IN GENERAL.—For 2011 through 2014, if an eligible professional meets the requirements described in subparagraph (B), the applicable quality percent for such year, as described in clauses (iii) and (iv) of paragraph (1)(B), shall be increased by 0.5 percentage points.

“(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

“(i) The eligible professional shall—

“(I) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year; and

“(II) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(i)) that meets—

“(aa) the criteria for a registry (as described in subsection (k)(4)); or

“(bb) an alternative form and manner determined appropriate by the Secretary.

“(ii) The eligible professional, more frequently than is required to qualify for or maintain board certification status—

“(I) participates in such a Maintenance of Certification program for a year; and

“(II) successfully completes a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

“(iii) A Maintenance of Certification program submits to the Secretary, on behalf of the eligible professional, information—

“(I) in a form and manner specified by the Secretary, that the eligible professional has successfully met the requirements of clause (ii)

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(i) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL.—The term “eligible professional” has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(2) PHYSICIAN.—The term “physician” has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) PHYSICIAN COMPARE.—The term “Physician Compare” means the Internet website developed under subsection (a)(1).

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

“(e) AVAILABILITY OF MEDICARE DATA.—

“(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

“(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

“(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

“(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

“(3) DATA DESCRIBED.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

“(4) REQUIREMENTS.—

“(A) FEE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited into the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

“(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

“(ii) (I) except as provided in subclause (II), if available, use standard measures, such as measures

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endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 931 of the Public Health Service Act; or

“(II) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

“(iii) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

“(iv) only include information on the evaluation of performance of providers and suppliers in reports described in subparagraph (C);

“(v) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

“(vi) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

“(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

“(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(ii)(II), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports;

“(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public release of such report, and provide an opportunity to appeal and correct errors;

“(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

“(iv) except as described in clause (ii), be made available to the public.

“(D) APPROVAL AND LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2012.