[DISCUSSION DRAFT]

112TH CONGRESS
2D SESSION

H. R. _____

To amend title XVIII of the Social Security Act to provide for a 5-year Medicare physician payment update, guarantee freedom of choice and contracting for patients under the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. PRICE of Georgia (for himself and Mr. BOUSTANY) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to provide for a 5-year Medicare physician payment update, guarantee freedom of choice and contracting for patients under the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PHYSICIAN PAYMENT UPDATE.

(a) 2013 THROUGH 2017.—Section 1848(d) of the Social Security Act (42 U.S.C. 10 1395w–4(d)) is amended by adding at the end the following new paragraph:

"(14) UPDATE FOR 2013 THROUGH 2017.—

"(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), and (13)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for each of 2013 through 2017 the update to the single conversion factor shall be the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for such year.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2018 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2018 and subsequent years as if subparagraph (A) had never applied.".

(b) PROPOSAL FOR FUTURE REFORM.—

(1) COLLECTION OF COMMENTS.—Not later than 18 months after the date of the enactment of this Act, 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 shall collect comments from health care stakeholders and others on recommendations for the purpose of reforming the method and

amounts of payments by which providers are paid under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including with respect to quality reporting, care coordination, and fundamental reform.

(2) LEGISLATIVE LANGUAGE.—Not later than 30 months after the date of the enactment of this Act, the Committees described in paragraph (1) shall provide for proposed legislative language to address the purpose described in such paragraph and future reductions in the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such proposed legislative language shall allow for flexibility of physician choice and take into consideration the comments collected under paragraph (1). Such legislative language shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House of Representatives by the majority leader of the House or by Members of the House designated by the majority leader of the House.

(3) VOTE ON PASSAGE.—Not later than 48 months after the date of the enactment of this Act,

the Senate and the House of Representatives shall vote on passage of a bill consisting of the proposed legislative language as amended.

SEC. 2. GUARANTEEING FREEDOM OF CHOICE AND CONTRACTING FOR PATIENTS UNDER MEDICARE.

(a) IN GENERAL.—Section 1802 of the Social Security Act (42 U.S.C. 1395a) is amended to read as follows:

''FREEDOM OF CHOICE AND CONTRACTING BY PATIENT GUARANTEED

''SEC. 1802. (a) BASIC FREEDOM OF CHOICE.—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide that individual such services.

''(b) FREEDOM TO CONTRACT BY MEDICARE BENEFICIARIES.—

''(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a Medicare beneficiary from entering into a contract with an eligible professional (whether or not the professional is a participating or non-participating physician or practitioner) for any item or service covered under this title.

''(2) SUBMISSION OF CLAIMS.—Any Medicare beneficiary that enters into a contract under this

section with an eligible professional shall be permitted to submit a claim for payment under this title for services furnished by such professional, and such payment shall be made in the amount that would otherwise apply to such professional under this title except that where such professional is considered to be non-participating, payment shall be paid as if the professional were participating. Payment made under this title for any item or service provided under the contract shall not render the professional a participating or non-participating physician or practitioner, and as such, requirements of this title that may otherwise apply to a participating or non-participating physician or practitioner would not apply with respect to any items or services furnished under the contract.

''(3) BENEFICIARY PROTECTIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

''(i) the contract is in writing, is signed by the Medicare beneficiary and the physician or practitioner, and establishes all terms of the contract (including specific payment for items and services covered by the contract) before any item or service is

provided pursuant to the contract, and the beneficiary shall be held harmless for any subsequent payment charged for a service in excess of the amount established under the contract during the period the contract is in effect;

"(ii) the contract contains the items described in subparagraph (B); and

"(iii) the contract is not entered into at a time when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation.

"(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the Medicare beneficiary that by signing such contract the beneficiary—

"(i) agrees to be responsible for payment to such eligible professional for such items or services under the terms of and amounts established under the contract;

"(ii) agrees to be responsible for submitting claims under this title to the Secretary, and to any other supplemental insurance plan that may provide supple-

mental insurance, for such items or services furnished under the contract if such items or services are covered by this title, unless otherwise provided in the contract under subparagraph (C)(i); and

"(iii) acknowledges that no limits or other payment incentives that may otherwise apply under this title (such as the limits under subsection (g) of section 1848 or incentives under subsection (a)(5), (m), (q), and (p) of such section) shall apply to amounts that may be charged, or paid to a beneficiary for, such items or services.

Such contract shall also clearly indicate whether the eligible professional is excluded from participation under the Medicare program under section 1128.

"(C) BENEFICIARY ELECTIONS UNDER THE CONTRACT.—Any Medicare beneficiary that enters into a contract under this section may elect to negotiate, as a term of the contract, a provision under which—

"(i) the eligible professional shall file claims on behalf of the beneficiary with the Secretary and any supplemental insurance

plan for items or services furnished under the contract if such items or services are covered under this title or under the plan; and

''(ii) the beneficiary assigns payment to the eligible professional for any claims filed by, or on behalf of, the beneficiary with the Secretary and any supplemental insurance plan for items or services furnished under the contract.

''(D) EXCLUSION OF DUAL ELIGIBLE INDIVIDUALS.—Paragraph (1) shall not apply to any contract if a beneficiary who is eligible for medical assistance under title XIX is a party to the contract.

''(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a Medicare beneficiary under a contract described in paragraph (1).

''(5) CONSTRUCTION.—Nothing in this section shall be construed—

''(A) to prohibit any eligible professional from maintaining an election and acting as a participating or non-participating physician or

practitioner with respect to any patient not covered under a contract established under this section; and

"(B) as changing the items and services for which an eligible professional may bill under this title.

"(6) DEFINITIONS.—In this subsection:

"(A) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given such term in section 1848(k)(3)(B).

"(C) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

"(i) serious jeopardy to the health of the individual or, in the case of a pregnant

woman, the health of the woman or her unborn child;

"(ii) serious impairment to bodily functions; or

"(iii) serious dysfunction of any bodily organ or part.

"(D) URGENT HEALTH CARE SITUATION.—The term 'urgent health care situation' means services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.".

SEC. 3. PREEMPTION OF STATE LAWS LIMITING CHARGES FOR ELIGIBLE PROFESSIONAL SERVICES.

(a) IN GENERAL.—No State may impose a limit on the amount of charges for services, furnished by an eligible professional (as defined in subsection (k)(3)(B) of section 1848 of the Social Security Act, 42 U.S.C. 1395w–4), for which payment is made under such section, and any such limit is hereby preempted.

(b) STATE.—In this section, the term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa.

SEC. 4. LIMITATION ON RECOVERY IN A HEALTH CARE LAWSUIT BASED ON COMPLIANCE WITH BEST PRACTICE GUIDELINES.

(a) SELECTION AND ISSUANCE OF BEST PRACTICES GUIDELINES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide for the selection and issuance of best practice guidelines for treatment of medical conditions (each in this subsection referred to as a ''guideline'') in accordance with paragraphs (2) and (3).

(2) DEVELOPMENT PROCESS.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall enter into a contract with a qualified physician consensus-building organization (such as the Physician Consortium for Performance Improvement), in concert and agreement with physician specialty organizations, to develop guidelines. The contract shall require that the organization submit guidelines to the agency not later than 18 months after the date of the enactment of this Act.

(3) ISSUANCE.—

(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall, after notice and opportunity for

public comment, make a rule that provides for the establishment of the guidelines submitted under paragraph (2).

(B) LIMITATION.—The Secretary may not make a rule that includes guidelines other than those submitted under paragraph (2).

(C) DISSEMINATION.—The Secretary shall post such guidelines on the public Internet web page of the Department of Health and Human Services.

(4) MAINTENANCE.—Not later than 4 years after the date of the enactment of this Act, and every 2 years thereafter, the Secretary shall review the guidelines and shall, as necessary, enter into contracts similar to the contract described in paragraph (2), and issue guidelines in a manner similar to the issuance of guidelines under paragraph (3).

(b) LIMITATION ON DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—In any health care lawsuit, a court may not award noneconomic damages with respect to treatment that is consistent with a guideline issued under subsection (a).

(2) LIMITATION ON PUNITIVE DAMAGES.—In any health care lawsuit, no punitive damages may be

awarded against a health care provider based on a claim that such treatment caused the claimant harm if—

(A) such treatment was subject to quality review by a qualified physician consensus-building organization and has been found to be safe, effective, and appropriate;

(B) such treatment was approved in a guideline that underwent full review by such organization, public comment, approval by the Secretary, and dissemination as described in subparagraph (a); or

(C) such medical treatment is generally recognized among qualified experts (including medical providers and relevant physician specialty organizations) as safe, effective, and appropriate.

(c) USE.—

(1) INTRODUCTION AS EVIDENCE.—Guidelines established in a rule made under subsection (a) may not be introduced as evidence of negligence or deviation in the standard of care in any health care lawsuit unless they have previously been introduced by the defendant.

(2) NO PRESUMPTION OF NEGLIGENCE.—There shall be no presumption of negligence if a health care provider provides treatment in a manner inconsistent with such guidelines.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing a State from—

(1) replacing the current medical malpractice rules of the State with rules that rely, as a defense, upon a health care provider's compliance with a guideline issued under subsection (a); or

(2) applying additional guidelines or safe-harbors that are in addition to, but not in lieu of, the guidelines issued under subsection (a).

SEC. 5. PERMITTING CERTAIN INCENTIVE PAYMENTS THAT PROMOTE QUALITY AND EFFICIENCY.

(a) IN GENERAL.—Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended by adding at the end the following new paragraph:

''(9) INCENTIVE PAYMENTS THAT PROMOTE QUALITY AND EFFICIENCY.—Any remuneration made, directly or indirectly, to a physician by a qualified hospital (as such term is defined in subsection (j)(2)) under the terms of a quality incentive agreement that meets the requirements of subsection (j)(1), for purposes of sharing cost savings gen-

erated for the hospital through the physician's voluntary participation in quality improvement activities under such agreement.''.

(b) REQUIREMENTS FOR INCENTIVE PAYMENTS.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

''(j) REQUIREMENTS FOR EXCEPTION FOR INCENTIVE PAYMENTS THAT PROMOTE QUALITY AND EFFICIENCY.—

''(1) QUALITY INCENTIVE AGREEMENT.—

''(A) IN GENERAL.—A quality incentive agreement that meets the requirements of this paragraph is an agreement between a physician and an qualified hospital that meets the following requirements:

''(i) QUALITY IMPROVEMENT ACTIVITIES.—The agreement lists the quality improvement activities under the hospital's quality improvement program that the physician agrees to participate in under the agreement.

''(ii) DETERMINATION OF REMUNERATION.—The agreement specifies that remuneration will be made to the physician by

the hospital for cost savings achieved through the physician's participation in the quality improvement activities under clause (i), and includes the methodology that will be used to determine—

"(I) the cost savings achieved through the physician's participation in such activities; and

"(II) subject to any limitation under paragraph (3)(A), the amount of any remuneration made to the physician under such agreement.

"(iii) RECORDS.—The agreement contains a requirement that the physician and the hospital retain records related to the agreement, including records related to any remuneration made under the agreement, for a period determined by the Secretary. At the request of the Secretary, the physician and the hospital make shall such records available to the Secretary for purposes an audit conducted by the Secretary under paragraph (3)(B).

"(B) LIMITATION ON BASIS OF PAYMENT.—The quality incentive agreement under

subparagraph (A) may not allow remuneration to be made on the basis of—

"(i) the volume of referrals made by the physician to the hospital;

"(ii) the value of referrals made by the physician to the hospital;

"(iii) cost savings achieved through limiting or denying a beneficiary's access to items or services solely on the basis that such services are new or improved; or

"(iv) cost saving achieved through directly or indirectly reducing or restricting the provision of items and services which the physician involved determines to be medically necessary or medically appropriate.

"(2) QUALIFIED HOSPITAL.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'qualified hospital' means a hospital that—

"(i) has established and maintains a quality improvement program that contains a list of quality improvement activities that meet the requirements of subparagraph

(B) that the hospital seeks to encourage physicians to participate in;

''(ii) makes payments to the Secretary under subparagraph (C);

''(iii) provides notice to beneficiaries that meet the requirements under subparagraph (D);

''(iv) complies with the requirements of subparagraph (E), related to physician independence; and

''(v) submits the annual report required under subparagraph (F).

''(B) QUALITY IMPROVEMENT ACTIVITIES.—

''(i) IN GENERAL.—With respect to a quality improvement program of a hospital under subparagraph (A)(i), a quality improvement activity is an activity—

''(I) that is designed by the hospital to—

''(aa) improve the quality of inpatient hospital care (including improvements in patient safety); and

"(bb) generate cost savings for the hospital; and

"(II) does not jeopardize patient health or safety.

"(ii) FLEXIBILITY.—A quality improvement activity may be designed to—

"(I) be clinical or non-clinical in nature;

"(II) increase communication and coordination between physicians and other providers;

"(III) improve admission planning, discharge planning, operating room utilization, timely documentation of the medical record, or appropriate transfer of patients within departments of a hospital;

"(IV) reduce the rate of avoidable re-operations;

"(V) reduce avoidable readmissions;

"(VI) appropriately reduce the average length of stay for patients in a hospital; or

"(VII) make other appropriate quality improvements, based on quality improvement measures recommended by physician specialty societies, the National Quality Forum, the National Committee for Quality Assurance, and the Physician Consortium for Performance Improvement.

"(iii) OTHER REQUIREMENTS.—

"(I) QUALITY AND COST BENCHMARKS.—The hospital shall include the quality and cost benchmarks that the hospital uses to determine if an activity is a quality improvement activity in the quality improvement program under subparagraph (A)(i).

"(II) LIMITATION.—A quality improvement program may not include incentives to encourage the hospital or a physician to avoid taking on difficult or complex cases, which, but for the remuneration permitted under subsection (e)(9), the hospital or provider would have taken on.

"(C) SHARED SAVINGS WITH MEDICARE.—For each year (except for the first such year) that a hospital makes remuneration under subsection (e)(9), the hospital shall make, at such time and in such manner as the Secretary may require, a payment to the Secretary in an amount that is determined by the Secretary, but exceeds one percent of cost savings generated in such year as a result of physician participation in quality improvement activities through a quality incentive agreement under paragraph (1). Any payments made by a hospital to the Secretary under this subparagraph shall be deposited in the Federal hospital insurance trust fund.

"(D) NOTICE REQUIREMENTS.—

"(i) IN GENERAL.—A hospital that is a party to a quality incentive agreement under paragraph (1) shall, during the period of such agreement—

"(I) provide notice to each beneficiary who receives inpatient hospital services in such hospital that the hospital provides remuneration to physi-

cians who voluntarily participate in such agreement; and

"(II) disclose and prominently display on the public Internet website of the hospital information about the hospital's participation in such agreement and the remuneration made under such agreement.

"(ii) TIMING.—To the extent that is feasible, without compromising patient safety, the notice under clause (i)(I) shall be provided to a beneficiary before such beneficiary receives inpatient hospital services through the hospital.

"(E) PROTECTION OF PHYSICIAN INDEPENDENCE.—An qualified hospital may not—

"(i) require that any physician who works for the hospital (as an employee, an independent contractor, or in any other status) to enter into a quality incentive agreement under paragraph (1); or

"(ii) penalize such physician (except through a denial of remuneration under subsection (e)(9), subject to the terms of the agreement under paragraph (1)) for

the failure of such physician to participate in the quality improvement activities under the hospital's quality improvement program.

''(F) ANNUAL REPORT.—A hospital shall submit to the Secretary an annual report that includes—

''(i) a copy of the hospital's quality improvement program;

''(ii) a list of the major quality improvement activities for which remuneration was made under any quality incentive agreement to which the hospital is a party during the previous year;

''(iii) the amount of cost savings generated for the hospital by such quality improvement activities during such year; and

''(iv) the quality improvement activities that generated the most cost savings for the hospital.

''(3) RESPONSIBILITIES OF THE SECRETARY.—

''(A) AUTHORITY TO SET LIMITS TO PREVENT MISUSE OF INCENTIVE PAYMENTS.—The Secretary may set a limit to the amount of remuneration that a hospital may make to a phy-

sician under an agreement under paragraph (1) for the purpose of the types of remuneration prohibited under clauses (i) or (ii) of paragraph (1)(B).

''(B) AUDITS.—The Secretary, may, in such time and manner as the Secretary may specify, audit a hospital or physician with respect to remuneration made pursuant to a quality incentive agreement under paragraph (1).

''(C) PUBLIC DISCLOSURE OF PARTICIPATING HOSPITALS ON WEBSITE.—The Secretary shall maintain and publish a list of hospitals that have quality incentive agreements under paragraph (1) on the Medicare.gov Internet website of the Centers for Medicare & Medicaid Services.''.

(c) QUALITY INCENTIVE OMBUDSMAN.—Section 1808(c) of such Act (42 U.S.C. 1395b–9(c)) is amended by adding at the end the following new paragraph:

''(4) QUALITY INCENTIVE OMBUDSMAN.—

''(A) IN GENERAL.—The Secretary shall provide a quality incentive ombudsman with Centers for Medicare & Medicaid Services, who shall respond to complaints and inquiries made by individuals described under paragraph

(2)(A), hospitals, and physicians relating to the remuneration permitted under section 1877(e)(9).

"(B) OFFICE AND REPORT.—The quality incentive ombudsman may be within the office of the Medicare Beneficiary Ombudsman appointed under paragraph (1), and the activities of the quality incentive ombudsman shall be included in the report under paragraph (2)(C).".

(d) REGULATIONS.—

(1) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall promulgate regulations to implement subsections (e)(9) and (j) of section 1887 of the Social Security Act, as added by subsection (a). Such regulations may include model quality incentive agreements and quality improvement programs.

(2) CONSULTATION.—In developing the regulations under paragraph (1), the Secretary of Health and Human Services shall consult with physician specialty societies, hospitals, and individuals entitled to benefits under part A or enrolled under part B of title XVIII of the Social Security Act.

(3) FEDERAL TRADE COMMISSION AND DEPARTMENT OF JUSTICE.—Not later than January 1,

2014, to the extent that quality incentive agreements under section 1877(j) of the Social Security Act may implicate anti-trust laws and regulations, the Federal Trade Commission and the Attorney General shall review such laws and regulations and shall issue regulations or guidance that includes examples of quality incentive agreements (as such term is used in section 1877(j) of the Social Security Act) that are permitted under such laws and regulations, and examples of such agreements that are not permitted under such laws and regulations.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to remuneration made on or after January 1, 2014.

SEC. 6. EXCEPTION TO CIVIL MONETARY PENALTIES FOR CERTAIN INCENTIVE PAYMENTS.

Section 1128A(b)(1) of the Social Security Act (42 U.S.C. 1320a-7a(b)(1)) is amended, in the matter preceding subparagraph (A), by inserting " (except for remuneration made pursuant to section 1877(e)(9))" after "makes a payment".

SEC. 7. ESTABLISHMENT OF A SAFE HARBOR FROM CERTAIN CRIMINAL PENALTIES TO PROVIDE FOR USE OF INCENTIVE PAYMENT PROGRAMS BETWEEN PHYSICIANS AND HOSPITALS.

Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(1) in subparagraph (I), by striking ''and'' at the end;

(2) in subparagraph (J), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(K) any remuneration between a hospital and a physician that made pursuant to section 1877(e)(9).''.