

Calendar No. 327

113TH CONGRESS
2^D SESSION

S. 2110

To amend titles XVIII and XIX of the Social Security Act to repeal the Medicare sustainable growth rate and to improve Medicare and Medicaid payments, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 11, 2014

Mr. WYDEN introduced the following bill; which was read the first time

MARCH 12, 2014

Read the second time and placed on the calendar

A BILL

To amend titles XVIII and XIX of the Social Security Act to repeal the Medicare sustainable growth rate and to improve Medicare and Medicaid payments, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare SGR Repeal and Beneficiary Access Improve-
6 ment Act of 2014”.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE PAYMENT FOR PHYSICIANS' SERVICES

Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians' services.

Sec. 102. Priorities and funding for measure development.

Sec. 103. Encouraging care management for individuals with chronic care needs.

Sec. 104. Ensuring accurate valuation of services under the physician fee schedule.

Sec. 105. Promoting evidence-based care.

Sec. 106. Empowering beneficiary choices through access to information on physicians' services.

Sec. 107. Expanding availability of Medicare data.

Sec. 108. Reducing administrative burden and other provisions.

TITLE II—EXTENSIONS

Subtitle A—Medicare Extensions

Sec. 201. Work geographic adjustment.

Sec. 202. Medicare payment for therapy services.

Sec. 203. Medicare ambulance services.

Sec. 204. Revision of the Medicare-dependent hospital (MDH) program.

Sec. 205. Revision of Medicare inpatient hospital payment adjustment for low-volume hospitals.

Sec. 206. Specialized Medicare Advantage plans for special needs individuals.

Sec. 207. Reasonable cost reimbursement contracts.

Sec. 208. Quality measure endorsement and selection.

Sec. 209. Permanent extension of funding outreach and assistance for low-income programs.

Subtitle B—Medicaid and Other Extensions

Sec. 211. Qualifying individual program.

Sec. 212. Transitional Medical Assistance.

Sec. 213. Express lane eligibility.

Sec. 214. Pediatric quality measures.

Sec. 215. Special diabetes programs.

Subtitle C—Human Services Extensions

Sec. 221. Abstinence education grants.

Sec. 222. Personal responsibility education program.

Sec. 223. Family-to-family health information centers.

Sec. 224. Health workforce demonstration project for low-income individuals.

TITLE III—MEDICARE AND MEDICAID PROGRAM INTEGRITY

Sec. 301. Reducing improper Medicare payments.

- Sec. 302. Authority for Medicaid fraud control units to investigate and prosecute complaints of abuse and neglect of Medicaid patients in home and community-based settings.
- Sec. 303. Improved use of funds received by the HHS Inspector General from oversight and investigative activities.
- Sec. 304. Preventing and reducing improper Medicare and Medicaid expenditures.

TITLE IV—OTHER PROVISIONS

- Sec. 401. Commission on Improving Patient Directed Health Care.
- Sec. 402. Expansion of the definition of inpatient hospital services for certain cancer hospitals.
- Sec. 403. Quality measures for certain post-acute care providers relating to notice and transfer of patient health information and patient care preferences.
- Sec. 404. Criteria for medically necessary, short inpatient hospital stays.
- Sec. 405. Transparency of reasons for excluding additional procedures from the Medicare ambulatory surgical center (ASC) approved list.
- Sec. 406. Supervision in critical access hospitals.
- Sec. 407. Requiring State licensure of bidding entities under the competitive acquisition program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).
- Sec. 408. Recognition of attending physician assistants as attending physicians to serve hospice patients.
- Sec. 409. Remote patient monitoring pilot projects.
- Sec. 410. Community-Based Institutional Special Needs Plan Demonstration Program.
- Sec. 411. Applying CMMI waiver authority to PACE in order to foster innovations.
- Sec. 412. Improve and modernize Medicaid data systems and reporting.
- Sec. 413. Fairness in Medicaid supplemental needs trusts.
- Sec. 414. Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians.
- Sec. 415. Demonstration program to improve community mental health services.
- Sec. 416. Annual Medicaid DSH report.
- Sec. 417. Implementation.

1 **TITLE I—MEDICARE PAYMENT**
2 **FOR PHYSICIANS’ SERVICES**
3 **SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE**
4 **(SGR) AND IMPROVING MEDICARE PAYMENT**
5 **FOR PHYSICIANS’ SERVICES.**
6 (a) STABILIZING FEE UPDATES.—

1 (1) REPEAL OF SGR PAYMENT METHOD-
2 OLOGY.—Section 1848 of the Social Security Act
3 (42 U.S.C. 1395w–4) is amended—

4 (A) in subsection (d)—

5 (i) in paragraph (1)(A), by inserting
6 “or a subsequent paragraph” after “para-
7 graph (4)”; and

8 (ii) in paragraph (4)—

9 (I) in the heading, by inserting
10 “AND ENDING WITH 2013” after
11 “YEARS BEGINNING WITH 2001”; and

12 (II) in subparagraph (A), by in-
13 serting “and ending with 2013” after
14 “a year beginning with 2001”; and

15 (B) in subsection (f)—

16 (i) in paragraph (1)(B), by inserting
17 “through 2013” after “of each succeeding
18 year”; and

19 (ii) in paragraph (2), in the matter
20 preceding subparagraph (A), by inserting
21 “and ending with 2013” after “beginning
22 with 2000”.

23 (2) UPDATE OF RATES FOR APRIL THROUGH
24 DECEMBER OF 2014, 2015, AND SUBSEQUENT
25 YEARS.—Subsection (d) of section 1848 of the Social

1 Security Act (42 U.S.C. 1395w-4) is amended by
2 striking paragraph (15) and inserting the following
3 new paragraphs:

4 “(15) UPDATE FOR 2014 THROUGH 2018.—The
5 update to the single conversion factor established in
6 paragraph (1)(C) for 2014 and each subsequent
7 year through 2018 shall be 0.5 percent.

8 “(16) UPDATE FOR 2019 THROUGH 2023.—The
9 update to the single conversion factor established in
10 paragraph (1)(C) for 2019 and each subsequent
11 year through 2023 shall be zero percent.

12 “(17) UPDATE FOR 2024 AND SUBSEQUENT
13 YEARS.—The update to the single conversion factor
14 established in paragraph (1)(C) for 2024 and each
15 subsequent year shall be—

16 “(A) for items and services furnished by a
17 qualifying APM participant (as defined in sec-
18 tion 1833(z)(2)) for such year, 1.0 percent; and

19 “(B) for other items and services, 0.5 per-
20 cent.”.

21 (3) MEDPAC REPORTS.—

22 (A) INITIAL REPORT.—Not later than July
23 1, 2016, the Medicare Payment Advisory Com-
24 mission shall submit to Congress a report on
25 the relationship between—

1 (i) physician and other health profes-
2 sional utilization and expenditures (and the
3 rate of increase of such utilization and ex-
4 penditures) of items and services for which
5 payment is made under section 1848 of the
6 Social Security Act (42 U.S.C. 1395w-4);
7 and

8 (ii) total utilization and expenditures
9 (and the rate of increase of such utilization
10 and expenditures) under parts A, B, and D
11 of title XVIII of such Act.

12 Such report shall include a methodology to de-
13 scribe such relationship and the impact of
14 changes in such physician and other health pro-
15 fessional practice and service ordering patterns
16 on total utilization and expenditures under
17 parts A, B, and D of such title.

18 (B) FINAL REPORT.—Not later than July
19 1, 2020, the Medicare Payment Advisory Com-
20 mission shall submit to Congress a report on
21 the relationship described in subparagraph (A),
22 including the results determined from applying
23 the methodology included in the report sub-
24 mitted under such subparagraph.

1 (C) REPORT ON UPDATE TO PHYSICIANS'
2 SERVICES UNDER MEDICARE.—Not later than
3 July 1, 2018, the Medicare Payment Advisory
4 Commission shall submit to Congress a report
5 on—

6 (i) the payment update for profes-
7 sional services applied under the Medicare
8 program under title XVIII of the Social
9 Security Act for the period of years 2014
10 through 2018;

11 (ii) the effect of such update on the
12 efficiency, economy, and quality of care
13 provided under such program;

14 (iii) the effect of such update on en-
15 suring a sufficient number of providers to
16 maintain access to care by Medicare bene-
17 ficiaries; and

18 (iv) recommendations for any future
19 payment updates for professional services
20 under such program to ensure adequate
21 access to care is maintained for Medicare
22 beneficiaries.

23 (b) CONSOLIDATION OF CERTAIN CURRENT LAW
24 PERFORMANCE PROGRAMS WITH NEW MERIT-BASED IN-
25 CENTIVE PAYMENT SYSTEM.—

1 (1) EHR MEANINGFUL USE INCENTIVE PRO-
2 GRAM.—

3 (A) SUNSETTING SEPARATE MEANINGFUL
4 USE PAYMENT ADJUSTMENTS.—Section
5 1848(a)(7)(A) of the Social Security Act (42
6 U.S.C. 1395w-4(a)(7)(A)) is amended—

7 (i) in clause (i), by striking “2015 or
8 any subsequent payment year” and insert-
9 ing “2015, 2016, or 2017”;

10 (ii) in clause (ii)—

11 (I) in the matter preceding sub-
12 clause (I), by striking “Subject to
13 clause (iii), for” and inserting “For”;
14 and

15 (II) in subclause (III), by strik-
16 ing “and each subsequent year”; and
17 (iii) by striking clause (iii).

18 (B) CONTINUATION OF MEANINGFUL USE
19 DETERMINATIONS FOR MIPS.—Section
20 1848(o)(2) of the Social Security Act (42
21 U.S.C. 1395w-4(o)(2)) is amended—

22 (i) in subparagraph (A), in the matter
23 preceding clause (i)—

1 (I) by striking “For purposes of
2 paragraph (1), an” and inserting
3 “An”; and

4 (II) by inserting “, or pursuant
5 to subparagraph (D) for purposes of
6 subsection (q), for a performance pe-
7 riod under such subsection for a year”
8 after “under such subsection for a
9 year”; and

10 (ii) by adding at the end the following
11 new subparagraph:

12 “(D) CONTINUED APPLICATION FOR PUR-
13 POSES OF MIPS.—With respect to 2018 and
14 each subsequent payment year, the Secretary
15 shall, for purposes of subsection (q) and in ac-
16 cordance with paragraph (1)(F) of such sub-
17 section, determine whether an eligible profes-
18 sional who is a MIPS eligible professional (as
19 defined in subsection (q)(1)(C)) for such year is
20 a meaningful EHR user under this paragraph
21 for the performance period under subsection (q)
22 for such year.”.

23 (2) QUALITY REPORTING.—

24 (A) SUNSETTING SEPARATE QUALITY RE-
25 PORTING INCENTIVES.—Section 1848(a)(8)(A)

1 of the Social Security Act (42 U.S.C. 1395w–
2 4(a)(8)(A)) is amended—

3 (i) in clause (i), by striking “2015 or
4 any subsequent year” and inserting “2015,
5 2016, or 2017”; and

6 (ii) in clause (ii)(II), by striking “and
7 each subsequent year” and inserting “and
8 2017”.

9 (B) CONTINUATION OF QUALITY MEAS-
10 URES AND PROCESSES FOR MIPS.—Section
11 1848 of the Social Security Act (42 U.S.C.
12 1395w–4) is amended—

13 (i) in subsection (k), by adding at the
14 end the following new paragraph:

15 “(9) CONTINUED APPLICATION FOR PURPOSES
16 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-
17 TEERING TO REPORT.—The Secretary shall, in ac-
18 cordance with subsection (q)(1)(F), carry out the
19 provisions of this subsection—

20 “(A) for purposes of subsection (q); and

21 “(B) for eligible professionals who are not
22 MIPS eligible professionals (as defined in sub-
23 section (q)(1)(C)) for the year involved.”; and

24 (ii) in subsection (m)—

1 (I) by redesignating paragraph
2 (7) added by section 10327(a) of Pub-
3 lic Law 111–148 as paragraph (8);
4 and

5 (II) by adding at the end the fol-
6 lowing new paragraph:

7 “(9) CONTINUED APPLICATION FOR PURPOSES
8 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-
9 TEERING TO REPORT.—The Secretary shall, in ac-
10 cordance with subsection (q)(1)(F), carry out the
11 processes under this subsection—

12 “(A) for purposes of subsection (q); and

13 “(B) for eligible professionals who are not
14 MIPS eligible professionals (as defined in sub-
15 section (q)(1)(C)) for the year involved.”.

16 (3) VALUE-BASED PAYMENTS.—

17 (A) SUNSETTING SEPARATE VALUE-BASED
18 PAYMENTS.—Clause (iii) of section
19 1848(p)(4)(B) of the Social Security Act (42
20 U.S.C. 1395w–4(p)(4)(B)) is amended to read
21 as follows:

22 “(iii) APPLICATION.—The Secretary
23 shall apply the payment modifier estab-
24 lished under this subsection for items and
25 services furnished on or after January 1,

1 2015, but before January 1, 2018, with re-
2 spect to specific physicians and groups of
3 physicians the Secretary determines appro-
4 priate. Such payment modifier shall not be
5 applied for items and services furnished on
6 or after January 1, 2018.”.

7 (B) CONTINUATION OF VALUE-BASED PAY-
8 MENT MODIFIER MEASURES FOR MIPS.—Section
9 1848(p) of the Social Security Act (42 U.S.C.
10 1395w–4(p)) is amended—

11 (i) in paragraph (2), by adding at the
12 end the following new subparagraph:

13 “(C) CONTINUED APPLICATION FOR PUR-
14 POSES OF MIPS.—The Secretary shall, in ac-
15 cordance with subsection (q)(1)(F), carry out
16 subparagraph (B) for purposes of subsection
17 (q).”; and

18 (ii) in paragraph (3), by adding at the
19 end the following: “With respect to 2018
20 and each subsequent year, the Secretary
21 shall, in accordance with subsection
22 (q)(1)(F), carry out this paragraph for
23 purposes of subsection (q).”.

24 (c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

1 (1) IN GENERAL.—Section 1848 of the Social
2 Security Act (42 U.S.C. 1395w-4) is amended by
3 adding at the end the following new subsection:

4 “(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

5 “(1) ESTABLISHMENT.—

6 “(A) IN GENERAL.—Subject to the suc-
7 ceeding provisions of this subsection, the Sec-
8 retary shall establish an eligible professional
9 Merit-based Incentive Payment System (in this
10 subsection referred to as the ‘MIPS’) under
11 which the Secretary shall—

12 “(i) develop a methodology for assess-
13 ing the total performance of each MIPS el-
14 igible professional according to perform-
15 ance standards under paragraph (3) for a
16 performance period (as established under
17 paragraph (4)) for a year;

18 “(ii) using such methodology, provide
19 for a composite performance score in ac-
20 cordance with paragraph (5) for each such
21 professional for each performance period;
22 and

23 “(iii) use such composite performance
24 score of the MIPS eligible professional for
25 a performance period for a year to deter-

1 mine and apply a MIPS adjustment factor
2 (and, as applicable, an additional MIPS
3 adjustment factor) under paragraph (6) to
4 the professional for the year.

5 “(B) PROGRAM IMPLEMENTATION.—The
6 MIPS shall apply to payments for items and
7 services furnished on or after January 1, 2018.

8 “(C) MIPS ELIGIBLE PROFESSIONAL DE-
9 FINED.—

10 “(i) IN GENERAL.—For purposes of
11 this subsection, subject to clauses (ii) and
12 (iv), the term ‘MIPS eligible professional’
13 means—

14 “(I) for the first and second
15 years for which the MIPS applies to
16 payments (and for the performance
17 period for such first and second year),
18 a physician (as defined in section
19 1861(r)), a physician assistant, nurse
20 practitioner, and clinical nurse spe-
21 cialist (as such terms are defined in
22 section 1861(aa)(5)), and a certified
23 registered nurse anesthetist (as de-
24 fined in section 1861(bb)(2)) and a

1 group that includes such profes-
2 sionals; and

3 “(II) for the third year for which
4 the MIPS applies to payments (and
5 for the performance period for such
6 third year) and for each succeeding
7 year (and for the performance period
8 for each such year), the professionals
9 described in subclause (I) and such
10 other eligible professionals (as defined
11 in subsection (k)(3)(B)) as specified
12 by the Secretary and a group that in-
13 cludes such professionals.

14 “(ii) EXCLUSIONS.—For purposes of
15 clause (i), the term ‘MIPS eligible profes-
16 sional’ does not include, with respect to a
17 year, an eligible professional (as defined in
18 subsection (k)(3)(B)) who—

19 “(I) is a qualifying APM partici-
20 pant (as defined in section
21 1833(z)(2));

22 “(II) subject to clause (vii), is a
23 partial qualifying APM participant (as
24 defined in clause (iii)) for the most re-
25 cent period for which data are avail-

1 able and who, for the performance pe-
2 riod with respect to such year, does
3 not report on applicable measures and
4 activities described in paragraph
5 (2)(B) that are required to be re-
6 ported by such a professional under
7 the MIPS; or

8 “(III) for the performance period
9 with respect to such year, does not ex-
10 ceed the low-volume threshold meas-
11 urement selected under clause (iv).

12 “(iii) PARTIAL QUALIFYING APM PAR-
13 TICIPANT.—For purposes of this subpara-
14 graph, the term ‘partial qualifying APM
15 participant’ means, with respect to a year,
16 an eligible professional for whom the Sec-
17 retary determines the minimum payment
18 percentage (or percentages), as applicable,
19 described in paragraph (2) of section
20 1833(z) for such year have not been satis-
21 fied, but who would be considered a quali-
22 fying APM participant (as defined in such
23 paragraph) for such year if—

24 “(I) with respect to 2018 and
25 2019, the reference in subparagraph

1 (A) of such paragraph to 25 percent
2 was instead a reference to 20 percent;

3 “(II) with respect to 2020 and
4 2021—

5 “(aa) the reference in sub-
6 paragraph (B)(i) of such para-
7 graph to 50 percent was instead
8 a reference to 40 percent; and

9 “(bb) the references in sub-
10 paragraph (B)(ii) of such para-
11 graph to 50 percent and 25 per-
12 cent of such paragraph were in-
13 stead references to 40 percent
14 and 20 percent, respectively; and

15 “(III) with respect to 2022 and
16 subsequent years—

17 “(aa) the reference in sub-
18 paragraph (C)(i) of such para-
19 graph to 75 percent was instead
20 a reference to 50 percent; and

21 “(bb) the references in sub-
22 paragraph (C)(ii) of such para-
23 graph to 75 percent and 25 per-
24 cent of such paragraph were in-

1 stead references to 50 percent
2 and 20 percent, respectively.

3 “(iv) SELECTION OF LOW-VOLUME
4 THRESHOLD MEASUREMENT.—The Sec-
5 retary shall select a low-volume threshold
6 to apply for purposes of clause (ii)(III),
7 which may include one or more or a com-
8 bination of the following:

9 “(I) The minimum number (as
10 determined by the Secretary) of indi-
11 viduals enrolled under this part who
12 are treated by the eligible professional
13 for the performance period involved.

14 “(II) The minimum number (as
15 determined by the Secretary) of items
16 and services furnished to individuals
17 enrolled under this part by such pro-
18 fessional for such performance period.

19 “(III) The minimum amount (as
20 determined by the Secretary) of al-
21 lowed charges billed by such profes-
22 sional under this part for such per-
23 formance period.

24 “(v) TREATMENT OF NEW MEDICARE
25 ENROLLED ELIGIBLE PROFESSIONALS.—In

1 the case of a professional who first be-
2 comes a Medicare enrolled eligible profes-
3 sional during the performance period for a
4 year (and had not previously submitted
5 claims under this title such as a person, an
6 entity, or a part of a physician group or
7 under a different billing number or tax
8 identifier), such professional shall not be
9 treated under this subsection as a MIPS
10 eligible professional until the subsequent
11 year and performance period for such sub-
12 sequent year.

13 “(vi) CLARIFICATION.—In the case of
14 items and services furnished during a year
15 by an individual who is not a MIPS eligible
16 professional (including pursuant to clauses
17 (ii) and (v)) with respect to a year, in no
18 case shall a MIPS adjustment factor (or
19 additional MIPS adjustment factor) under
20 paragraph (6) apply to such individual for
21 such year.

22 “(vii) PARTIAL QUALIFYING APM PAR-
23 TICIPANT CLARIFICATIONS.—

24 “(I) TREATMENT AS MIPS ELIGI-
25 BLE PROFESSIONAL.—In the case of

1 an eligible professional who is a par-
2 tial qualifying APM participant, with
3 respect to a year, and who for the
4 performance period for such year re-
5 ports on applicable measures and ac-
6 tivities described in paragraph (2)(B)
7 that are required to be reported by
8 such a professional under the MIPS,
9 such eligible professional is considered
10 to be a MIPS eligible professional
11 with respect to such year.

12 “(II) NOT ELIGIBLE FOR QUALI-
13 FYING APM PARTICIPANT PAY-
14 MENTS.—In no case shall an eligible
15 professional who is a partial quali-
16 fying APM participant, with respect
17 to a year, be considered a qualifying
18 APM participant (as defined in para-
19 graph (2) of section 1833(z)) for such
20 year or be eligible for the additional
21 payment under paragraph (1) of such
22 section for such year.

23 “(D) APPLICATION TO GROUP PRAC-
24 TICES.—

25 “(i) IN GENERAL.—Under the MIPS:

1 “(I) QUALITY PERFORMANCE
2 CATEGORY.—The Secretary shall es-
3 tablish and apply a process that in-
4 cludes features of the provisions of
5 subsection (m)(3)(C) for MIPS eligi-
6 ble professionals in a group practice
7 with respect to assessing performance
8 of such group with respect to the per-
9 formance category described in clause
10 (i) of paragraph (2)(A).

11 “(II) OTHER PERFORMANCE CAT-
12 EGORIES.—The Secretary may estab-
13 lish and apply a process that includes
14 features of the provisions of sub-
15 section (m)(3)(C) for MIPS eligible
16 professionals in a group practice with
17 respect to assessing the performance
18 of such group with respect to the per-
19 formance categories described in
20 clauses (ii) through (iv) of such para-
21 graph.

22 “(ii) ENSURING COMPREHENSIVENESS
23 OF GROUP PRACTICE ASSESSMENT.—The
24 process established under clause (i) shall to
25 the extent practicable reflect the range of

1 items and services furnished by the MIPS
2 eligible professionals in the group practice
3 involved.

4 “(iii) CLARIFICATION.—MIPS eligible
5 professionals electing to be a virtual group
6 under paragraph (5)(I) shall not be consid-
7 ered MIPS eligible professionals in a group
8 practice for purposes of applying this sub-
9 paragraph.

10 “(E) USE OF REGISTRIES.—Under the
11 MIPS, the Secretary shall encourage the use of
12 qualified clinical data registries pursuant to
13 subsection (m)(3)(E) in carrying out this sub-
14 section.

15 “(F) APPLICATION OF CERTAIN PROVI-
16 SIONS.—In applying a provision of subsection
17 (k), (m), (o), or (p) for purposes of this sub-
18 section, the Secretary shall—

19 “(i) adjust the application of such
20 provision to ensure the provision is con-
21 sistent with the provisions of this sub-
22 section; and

23 “(ii) not apply such provision to the
24 extent that the provision is duplicative with
25 a provision of this subsection.

1 “(G) ACCOUNTING FOR RISK FACTORS.—

2 “(i) RISK FACTORS.—Taking into ac-
3 count the relevant studies conducted and
4 recommendations made in reports under
5 section 101(f)(1) of the Medicare SGR Re-
6 peal and Beneficiary Access Improvement
7 Act of 2014, the Secretary, on an ongoing
8 basis, shall estimate how an individual’s
9 health status and other risk factors affect
10 quality and resource use outcome measures
11 and, as feasible, shall incorporate informa-
12 tion from quality and resource use outcome
13 measurement (including care episode and
14 patient condition groups) into the MIPS.

15 “(ii) ACCOUNTING FOR OTHER FAC-
16 TORS IN PAYMENT ADJUSTMENTS.—Tak-
17 ing into account the studies conducted and
18 recommendations made in reports under
19 section 101(f)(1) of the Medicare SGR Re-
20 peal and Beneficiary Access Improvement
21 Act of 2014 and other information as ap-
22 propriate, the Secretary shall account for
23 identified factors with an effect on quality
24 and resource use outcome measures when
25 determining payment adjustments, com-

1 posite performance scores, scores for per-
2 formance categories, or scores for meas-
3 ures or activities under the MIPS.

4 “(2) MEASURES AND ACTIVITIES UNDER PER-
5 FORMANCE CATEGORIES.—

6 “(A) PERFORMANCE CATEGORIES.—Under
7 the MIPS, the Secretary shall use the following
8 performance categories (each of which is re-
9 ferred to in this subsection as a performance
10 category) in determining the composite per-
11 formance score under paragraph (5):

12 “(i) Quality.

13 “(ii) Resource use.

14 “(iii) Clinical practice improvement
15 activities.

16 “(iv) Meaningful use of certified EHR
17 technology.

18 “(B) MEASURES AND ACTIVITIES SPECI-
19 FIED FOR EACH CATEGORY.—For purposes of
20 paragraph (3)(A) and subject to subparagraph
21 (C), measures and activities specified for a per-
22 formance period (as established under para-
23 graph (4)) for a year are as follows:

24 “(i) QUALITY.—For the performance
25 category described in subparagraph (A)(i),

1 the quality measures included in the final
2 measures list published under subpara-
3 graph (D)(i) for such year and the list of
4 quality measures described in subpara-
5 graph (D)(vi) used by qualified clinical
6 data registries under subsection (m)(3)(E).

7 “(ii) RESOURCE USE.—For the per-
8 formance category described in subpara-
9 graph (A)(ii), the measurement of resource
10 use for such period under subsection
11 (p)(3), using the methodology under sub-
12 section (r) as appropriate, and, as feasible
13 and applicable, accounting for the cost of
14 drugs under part D.

15 “(iii) CLINICAL PRACTICE IMPROVE-
16 MENT ACTIVITIES.—For the performance
17 category described in subparagraph
18 (A)(iii), clinical practice improvement ac-
19 tivities (as defined in subparagraph
20 (C)(v)(III)) under subcategories specified
21 by the Secretary for such period, which
22 shall include at least the following:

23 “(I) The subcategory of expanded
24 practice access, which shall include ac-
25 tivities such as same day appoint-

1 ments for urgent needs and after
2 hours access to clinician advice.

3 “(II) The subcategory of popu-
4 lation management, which shall in-
5 clude activities such as monitoring
6 health conditions of individuals to pro-
7 vide timely health care interventions
8 or participation in a qualified clinical
9 data registry.

10 “(III) The subcategory of care
11 coordination, which shall include ac-
12 tivities such as timely communication
13 of test results, timely exchange of
14 clinical information to patients and
15 other providers, and use of remote
16 monitoring or telehealth.

17 “(IV) The subcategory of bene-
18 ficiary engagement, which shall in-
19 clude activities such as the establish-
20 ment of care plans for individuals
21 with complex care needs, beneficiary
22 self-management assessment and
23 training, and using shared decision-
24 making mechanisms.

1 “(V) The subcategory of patient
2 safety and practice assessment, such
3 as through use of clinical or surgical
4 checklists and practice assessments
5 related to maintaining certification.

6 “(VI) The subcategory of partici-
7 pation in an alternative payment
8 model (as defined in section
9 1833(z)(3)(C)).

10 In establishing activities under this clause,
11 the Secretary shall give consideration to
12 the circumstances of small practices (con-
13 sisting of 15 or fewer professionals) and
14 practices located in rural areas and in
15 health professional shortage areas (as des-
16 ignated under section 332(a)(1)(A) of the
17 Public Health Service Act).

18 “(iv) MEANINGFUL EHR USE.—For
19 the performance category described in sub-
20 paragraph (A)(iv), the requirements estab-
21 lished for such period under subsection
22 (o)(2) for determining whether an eligible
23 professional is a meaningful EHR user.

24 “(C) ADDITIONAL PROVISIONS.—

1 “(i) EMPHASIZING OUTCOME MEAS-
2 URES UNDER THE QUALITY PERFORMANCE
3 CATEGORY.—In applying subparagraph
4 (B)(i), the Secretary shall, as feasible, em-
5 phasize the application of outcome meas-
6 ures.

7 “(ii) APPLICATION OF ADDITIONAL
8 SYSTEM MEASURES.—The Secretary may
9 use measures used for a payment system
10 other than for physicians, such as meas-
11 ures for inpatient hospitals, for purposes of
12 the performance categories described in
13 clauses (i) and (ii) of subparagraph (A).
14 For purposes of the previous sentence, the
15 Secretary may not use measures for hos-
16 pital outpatient departments, except in the
17 case of emergency physicians.

18 “(iii) GLOBAL AND POPULATION-
19 BASED MEASURES.—The Secretary may
20 use global measures, such as global out-
21 come measures, and population-based
22 measures for purposes of the performance
23 category described in subparagraph (A)(i).

24 “(iv) APPLICATION OF MEASURES AND
25 ACTIVITIES TO NON-PATIENT-FACING PRO-

1 PROFESSIONALS.—In carrying out this para-
2 graph, with respect to measures and activi-
3 ties specified in subparagraph (B) for per-
4 formance categories described in subpara-
5 graph (A), the Secretary—

6 “(I) shall give consideration to
7 the circumstances of professional
8 types (or subcategories of those types
9 determined by practice characteris-
10 tics) who typically furnish services
11 that do not involve face-to-face inter-
12 action with a patient; and

13 “(II) may, to the extent feasible
14 and appropriate, take into account
15 such circumstances and apply under
16 this subsection with respect to MIPS
17 eligible professionals of such profes-
18 sional types or subcategories, alter-
19 native measures or activities that ful-
20 fill the goals of the applicable per-
21 formance category.

22 In carrying out the previous sentence, the
23 Secretary shall consult with professionals
24 of such professional types or subcategories.

1 “(v) CLINICAL PRACTICE IMPROVE-
2 MENT ACTIVITIES.—

3 “(I) REQUEST FOR INFORMA-
4 TION.—In initially applying subpara-
5 graph (B)(iii), the Secretary shall use
6 a request for information to solicit
7 recommendations from stakeholders to
8 identify activities described in such
9 subparagraph and specifying criteria
10 for such activities.

11 “(II) CONTRACT AUTHORITY FOR
12 CLINICAL PRACTICE IMPROVEMENT
13 ACTIVITIES PERFORMANCE CAT-
14 EGORY.—In applying subparagraph
15 (B)(iii), the Secretary may contract
16 with entities to assist the Secretary
17 in—

18 “(aa) identifying activities
19 described in subparagraph
20 (B)(iii);

21 “(bb) specifying criteria for
22 such activities; and

23 “(cc) determining whether a
24 MIPS eligible professional meets
25 such criteria.

1 “(III) CLINICAL PRACTICE IM-
2 PROVEMENT ACTIVITIES DEFINED.—
3 For purposes of this subsection, the
4 term ‘clinical practice improvement
5 activity’ means an activity that rel-
6 evant eligible professional organiza-
7 tions and other relevant stakeholders
8 identify as improving clinical practice
9 or care delivery and that the Sec-
10 retary determines, when effectively ex-
11 ecuted, is likely to result in improved
12 outcomes.

13 “(D) ANNUAL LIST OF QUALITY MEASURES
14 AVAILABLE FOR MIPS ASSESSMENT.—

15 “(i) IN GENERAL.—Under the MIPS,
16 the Secretary, through notice and comment
17 rulemaking and subject to the succeeding
18 clauses of this subparagraph, shall, with
19 respect to the performance period for a
20 year, establish an annual final list of qual-
21 ity measures from which MIPS eligible
22 professionals may choose for purposes of
23 assessment under this subsection for such
24 performance period. Pursuant to the pre-
25 vious sentence, the Secretary shall—

1 “(I) not later than November 1
2 of the year prior to the first day of
3 the first performance period under the
4 MIPS, establish and publish in the
5 Federal Register a final list of quality
6 measures; and

7 “(II) not later than November 1
8 of the year prior to the first day of
9 each subsequent performance period,
10 update the final list of quality meas-
11 ures from the previous year (and pub-
12 lish such updated final list in the Fed-
13 eral Register), by—

14 “(aa) removing from such
15 list, as appropriate, quality meas-
16 ures, which may include the re-
17 moval of measures that are no
18 longer meaningful (such as meas-
19 ures that are topped out);

20 “(bb) adding to such list, as
21 appropriate, new quality meas-
22 ures; and

23 “(cc) determining whether
24 or not quality measures on such
25 list that have undergone sub-

1 stantive changes should be in-
2 cluded in the updated list.

3 “(ii) CALL FOR QUALITY MEAS-
4 URES.—

5 “(I) IN GENERAL.—Eligible pro-
6 fessional organizations and other rel-
7 evant stakeholders shall be requested
8 to identify and submit quality meas-
9 ures to be considered for selection
10 under this subparagraph in the an-
11 nual list of quality measures published
12 under clause (i) and to identify and
13 submit updates to the measures on
14 such list. For purposes of the previous
15 sentence, measures may be submitted
16 regardless of whether such measures
17 were previously published in a pro-
18 posed rule or endorsed by an entity
19 with a contract under section 1890(a).

20 “(II) ELIGIBLE PROFESSIONAL
21 ORGANIZATION DEFINED.—In this
22 subparagraph, the term ‘eligible pro-
23 fessional organization’ means a pro-
24 fessional organization as defined by
25 nationally recognized multispecialty

1 boards of certification or equivalent
2 certification boards.

3 “(iii) REQUIREMENTS.—In selecting
4 quality measures for inclusion in the an-
5 nual final list under clause (i), the Sec-
6 retary shall—

7 “(I) provide that, to the extent
8 practicable, all quality domains (as
9 defined in subsection (s)(1)(B)) are
10 addressed by such measures; and

11 “(II) ensure that such selection
12 is consistent with the process for se-
13 lection of measures under subsections
14 (k), (m), and (p)(2).

15 “(iv) PEER REVIEW.—Before includ-
16 ing a new measure or a measure described
17 in clause (i)(II)(cc) in the final list of
18 measures published under clause (i) for a
19 year, the Secretary shall submit for publi-
20 cation in applicable specialty-appropriate
21 peer-reviewed journals such measure and
22 the method for developing and selecting
23 such measure, including clinical and other
24 data supporting such measure.

1 “(v) MEASURES FOR INCLUSION.—
2 The final list of quality measures published
3 under clause (i) shall include, as applica-
4 ble, measures under subsections (k), (m),
5 and (p)(2), including quality measures
6 from among—

7 “(I) measures endorsed by a con-
8 sensus-based entity;

9 “(II) measures developed under
10 subsection (s); and

11 “(III) measures submitted under
12 clause (ii)(I).

13 Any measure selected for inclusion in such
14 list that is not endorsed by a consensus-
15 based entity shall have a focus that is evi-
16 dence-based.

17 “(vi) EXCEPTION FOR QUALIFIED
18 CLINICAL DATA REGISTRY MEASURES.—
19 Measures used by a qualified clinical data
20 registry under subsection (m)(3)(E) shall
21 not be subject to the requirements under
22 clauses (i), (iv), and (v). The Secretary
23 shall publish the list of measures used by
24 such qualified clinical data registries on

1 the Internet website of the Centers for
2 Medicare & Medicaid Services.

3 “(vii) EXCEPTION FOR EXISTING
4 QUALITY MEASURES.—Any quality meas-
5 ure specified by the Secretary under sub-
6 section (k) or (m), including under sub-
7 section (m)(3)(E), and any measure of
8 quality of care established under sub-
9 section (p)(2) for the reporting period
10 under the respective subsection beginning
11 before the first performance period under
12 the MIPS—

13 “(I) shall not be subject to the
14 requirements under clause (i) (except
15 under items (aa) and (cc) of subclause
16 (II) of such clause) or to the require-
17 ment under clause (iv); and

18 “(II) shall be included in the
19 final list of quality measures pub-
20 lished under clause (i) unless removed
21 under clause (i)(II)(aa).

22 “(viii) CONSULTATION WITH REL-
23 EVANT ELIGIBLE PROFESSIONAL ORGANI-
24 ZATIONS AND OTHER RELEVANT STAKE-
25 HOLDERS.—Relevant eligible professional

1 organizations and other relevant stake-
2 holders, including State and national med-
3 ical societies, shall be consulted in carrying
4 out this subparagraph.

5 “(ix) OPTIONAL APPLICATION.—The
6 process under section 1890A is not re-
7 quired to apply to the selection of meas-
8 ures under this subparagraph.

9 “(3) PERFORMANCE STANDARDS.—

10 “(A) ESTABLISHMENT.—Under the MIPS,
11 the Secretary shall establish performance stand-
12 ards with respect to measures and activities
13 specified under paragraph (2)(B) for a perform-
14 ance period (as established under paragraph
15 (4)) for a year.

16 “(B) CONSIDERATIONS IN ESTABLISHING
17 STANDARDS.—In establishing such performance
18 standards with respect to measures and activi-
19 ties specified under paragraph (2)(B), the Sec-
20 retary shall consider the following:

21 “(i) Historical performance standards.

22 “(ii) Improvement.

23 “(iii) The opportunity for continued
24 improvement.

1 “(4) PERFORMANCE PERIOD.—The Secretary
2 shall establish a performance period (or periods) for
3 a year (beginning with the year described in para-
4 graph (1)(B)). Such performance period (or periods)
5 shall begin and end prior to the beginning of such
6 year and be as close as possible to such year. In this
7 subsection, such performance period (or periods) for
8 a year shall be referred to as the performance period
9 for the year.

10 “(5) COMPOSITE PERFORMANCE SCORE.—

11 “(A) IN GENERAL.—Subject to the suc-
12 ceeding provisions of this paragraph and taking
13 into account, as available and applicable, para-
14 graph (1)(G), the Secretary shall develop a
15 methodology for assessing the total performance
16 of each MIPS eligible professional according to
17 performance standards under paragraph (3)
18 with respect to applicable measures and activi-
19 ties specified in paragraph (2)(B) with respect
20 to each performance category applicable to such
21 professional for a performance period (as estab-
22 lished under paragraph (4)) for a year. Using
23 such methodology, the Secretary shall provide
24 for a composite assessment (using a scoring
25 scale of 0 to 100) for each such professional for

1 the performance period for such year. In this
2 subsection such a composite assessment for
3 such a professional with respect to a perform-
4 ance period shall be referred to as the ‘com-
5 posite performance score’ for such professional
6 for such performance period.

7 “(B) INCENTIVE TO REPORT; ENCOUR-
8 AGING USE OF CERTIFIED EHR TECHNOLOGY
9 FOR REPORTING QUALITY MEASURES.—

10 “(i) INCENTIVE TO REPORT.—Under
11 the methodology established under sub-
12 paragraph (A), the Secretary shall provide
13 that in the case of a MIPS eligible profes-
14 sional who fails to report on an applicable
15 measure or activity that is required to be
16 reported by the professional, the profes-
17 sional shall be treated as achieving the
18 lowest potential score applicable to such
19 measure or activity.

20 “(ii) ENCOURAGING USE OF CER-
21 TIFIED EHR TECHNOLOGY AND QUALIFIED
22 CLINICAL DATA REGISTRIES FOR REPORT-
23 ING QUALITY MEASURES.—Under the
24 methodology established under subpara-
25 graph (A), the Secretary shall—

1 “(I) encourage MIPS eligible
2 professionals to report on applicable
3 measures with respect to the perform-
4 ance category described in paragraph
5 (2)(A)(i) through the use of certified
6 EHR technology and qualified clinical
7 data registries; and

8 “(II) with respect to a perform-
9 ance period, with respect to a year,
10 for which a MIPS eligible professional
11 reports such measures through the
12 use of such EHR technology, treat
13 such professional as satisfying the
14 clinical quality measures reporting re-
15 quirement described in subsection
16 (o)(2)(A)(iii) for such year.

17 “(C) CLINICAL PRACTICE IMPROVEMENT
18 ACTIVITIES PERFORMANCE SCORE.—

19 “(i) RULE FOR ACCREDITATION.—A
20 MIPS eligible professional who is in a
21 practice that is certified as a patient-cen-
22 tered medical home or comparable spe-
23 cialty practice pursuant to subsection
24 (b)(8)(B)(i) with respect to a performance
25 period shall be given the highest potential

1 score for the performance category de-
2 scribed in paragraph (2)(A)(iii) for such
3 period.

4 “(ii) APM PARTICIPATION.—Partici-
5 pation by a MIPS eligible professional in
6 an alternative payment model (as defined
7 in section 1833(z)(3)(C)) with respect to a
8 performance period shall earn such eligible
9 professional a minimum score of one-half
10 of the highest potential score for the per-
11 formance category described in paragraph
12 (2)(A)(iii) for such performance period.

13 “(iii) SUBCATEGORIES.—A MIPS eli-
14 gible professional shall not be required to
15 perform activities in each subcategory
16 under paragraph (2)(B)(iii) or participate
17 in an alternative payment model in order
18 to achieve the highest potential score for
19 the performance category described in
20 paragraph (2)(A)(iii).

21 “(D) ACHIEVEMENT AND IMPROVE-
22 MENT.—

23 “(i) TAKING INTO ACCOUNT IMPROVE-
24 MENT.—Beginning with the second year to
25 which the MIPS applies, in addition to the

1 achievement of a MIPS eligible profes-
2 sional, if data sufficient to measure im-
3 provement is available, the methodology
4 developed under subparagraph (A)—

5 “(I) in the case of the perform-
6 ance score for the performance cat-
7 egory described in clauses (i) and (ii)
8 of paragraph (2)(A), shall take into
9 account the improvement of the pro-
10 fessional; and

11 “(II) in the case of performance
12 scores for other performance cat-
13 egories, may take into account the im-
14 provement of the professional.

15 “(ii) ASSIGNING HIGHER WEIGHT FOR
16 ACHIEVEMENT.—Beginning with the
17 fourth year to which the MIPS applies,
18 under the methodology developed under
19 subparagraph (A), the Secretary may as-
20 sign a higher scoring weight under sub-
21 subparagraph (F) with respect to the achieve-
22 ment of a MIPS eligible professional than
23 with respect to any improvement of such
24 professional applied under clause (i) with

1 respect to a measure, activity, or category
2 described in paragraph (2).

3 “(E) WEIGHTS FOR THE PERFORMANCE
4 CATEGORIES.—

5 “(i) IN GENERAL.—Under the meth-
6 odology developed under subparagraph (A),
7 subject to subparagraph (F)(i) and clauses
8 (ii) and (iii), the composite performance
9 score shall be determined as follows:

10 “(I) QUALITY.—

11 “(aa) IN GENERAL.—Sub-
12 ject to item (bb), thirty percent
13 of such score shall be based on
14 performance with respect to the
15 category described in clause (i) of
16 paragraph (2)(A). In applying
17 the previous sentence, the Sec-
18 retary shall, as feasible, encour-
19 age the application of outcome
20 measures within such category.

21 “(bb) FIRST 2 YEARS.—For
22 the first and second years for
23 which the MIPS applies to pay-
24 ments, the percentage applicable
25 under item (aa) shall be in-

1 creased in a manner such that
2 the total percentage points of the
3 increase under this item for the
4 respective year equals the total
5 number of percentage points by
6 which the percentage applied
7 under subclause (II)(bb) for the
8 respective year is less than 30
9 percent.

10 “(II) RESOURCE USE.—

11 “(aa) IN GENERAL.—Sub-
12 ject to item (bb), thirty percent
13 of such score shall be based on
14 performance with respect to the
15 category described in clause (ii)
16 of paragraph (2)(A).

17 “(bb) FIRST 2 YEARS.—For
18 the first year for which the MIPS
19 applies to payments, not more
20 than 10 percent of such score
21 shall be based on performance
22 with respect to the category de-
23 scribed in clause (ii) of para-
24 graph (2)(A). For the second
25 year for which the MIPS applies

1 to payments, not more than 15
2 percent of such score shall be
3 based on performance with re-
4 spect to the category described in
5 clause (ii) of paragraph (2)(A).

6 “(III) CLINICAL PRACTICE IM-
7 PROVEMENT ACTIVITIES.—Fifteen
8 percent of such score shall be based
9 on performance with respect to the
10 category described in clause (iii) of
11 paragraph (2)(A).

12 “(IV) MEANINGFUL USE OF CER-
13 TIFIED EHR TECHNOLOGY.—Twenty-
14 five percent of such score shall be
15 based on performance with respect to
16 the category described in clause (iv) of
17 paragraph (2)(A).

18 “(ii) AUTHORITY TO ADJUST PER-
19 CENTAGES IN CASE OF HIGH EHR MEAN-
20 INGFUL USE ADOPTION.—In any year in
21 which the Secretary estimates that the pro-
22 portion of eligible professionals (as defined
23 in subsection (o)(5)) who are meaningful
24 EHR users (as determined under sub-
25 section (o)(2)) is 75 percent or greater, the

1 Secretary may reduce the percent applica-
2 ble under clause (i)(IV), but not below 15
3 percent. If the Secretary makes such re-
4 duction for a year, subject to subclauses
5 (I)(bb) and (II)(bb) of clause (i), the per-
6 centages applicable under one or more of
7 subclauses (I), (II), and (III) of clause (i)
8 for such year shall be increased in a man-
9 ner such that the total percentage points
10 of the increase under this clause for such
11 year equals the total number of percentage
12 points reduced under the preceding sen-
13 tence for such year.

14 “(F) CERTAIN FLEXIBILITY FOR
15 WEIGHTING PERFORMANCE CATEGORIES, MEAS-
16 URES, AND ACTIVITIES.—Under the method-
17 ology under subparagraph (A), if there are not
18 sufficient measures and clinical practice im-
19 provement activities applicable and available to
20 each type of eligible professional involved, the
21 Secretary shall assign different scoring weights
22 (including a weight of 0)—

23 “(i) which may vary from the scoring
24 weights specified in subparagraph (E), for
25 each performance category based on the

1 extent to which the category is applicable
2 to the type of eligible professional involved;
3 and

4 “(ii) for each measure and activity
5 specified under paragraph (2)(B) with re-
6 spect to each such category based on the
7 extent to which the measure or activity is
8 applicable and available to the type of eli-
9 gible professional involved.

10 “(G) RESOURCE USE.—Analysis of the
11 performance category described in paragraph
12 (2)(A)(ii) shall include results from the method-
13 ology described in subsection (r)(5), as appro-
14 priate.

15 “(H) INCLUSION OF QUALITY MEASURE
16 DATA FROM OTHER PAYERS.—In applying sub-
17 sections (k), (m), and (p) with respect to meas-
18 ures described in paragraph (2)(B)(i), analysis
19 of the performance category described in para-
20 graph (2)(A)(i) may include data submitted by
21 MIPS eligible professionals with respect to
22 items and services furnished to individuals who
23 are not individuals entitled to benefits under
24 part A or enrolled under part B.

1 “(I) USE OF VOLUNTARY VIRTUAL GROUPS
2 FOR CERTAIN ASSESSMENT PURPOSES.—

3 “(i) IN GENERAL.—In the case of
4 MIPS eligible professionals electing to be a
5 virtual group under clause (ii) with respect
6 to a performance period for a year, for
7 purposes of applying the methodology
8 under subparagraph (A)—

9 “(I) the assessment of perform-
10 ance provided under such methodology
11 with respect to the performance cat-
12 egories described in clauses (i) and
13 (ii) of paragraph (2)(A) that is to be
14 applied to each such professional in
15 such group for such performance pe-
16 riod shall be with respect to the com-
17 bined performance of all such profes-
18 sionals in such group for such period;
19 and

20 “(II) the composite score pro-
21 vided under this paragraph for such
22 performance period with respect to
23 each such performance category for
24 each such MIPS eligible professional
25 in such virtual group shall be based

1 on the assessment of the combined
2 performance under subclause (I) for
3 the performance category and per-
4 formance period.

5 “(ii) ELECTION OF PRACTICES TO BE
6 A VIRTUAL GROUP.—The Secretary shall,
7 in accordance with clause (iii), establish
8 and have in place a process to allow an in-
9 dividual MIPS eligible professional or a
10 group practice consisting of not more than
11 10 MIPS eligible professionals to elect,
12 with respect to a performance period for a
13 year, for such individual MIPS eligible pro-
14 fessional or all such MIPS eligible profes-
15 sionals in such group practice, respectively,
16 to be a virtual group under this subpara-
17 graph with at least one other such indi-
18 vidual MIPS eligible professional or group
19 practice making such an election. Such a
20 virtual group may be based on geographic
21 areas or on provider specialties defined by
22 nationally recognized multispecialty boards
23 of certification or equivalent certification
24 boards and such other eligible professional
25 groupings in order to capture classifica-

1 tions of providers across eligible profes-
2 sional organizations and other practice
3 areas or categories.

4 “(iii) REQUIREMENTS.—The process
5 under clause (ii)—

6 “(I) shall provide that an election
7 under such clause, with respect to a
8 performance period, shall be made be-
9 fore or during the beginning of such
10 performance period and may not be
11 changed during such performance pe-
12 riod;

13 “(II) shall provide that a practice
14 described in such clause, and each
15 MIPS eligible professional in such
16 practice, may elect to be in no more
17 than one virtual group for a perform-
18 ance period; and

19 “(III) may provide that a virtual
20 group may be combined at the tax
21 identification number level.

22 “(6) MIPS PAYMENTS.—

23 “(A) MIPS ADJUSTMENT FACTOR.—Tak-
24 ing into account paragraph (1)(G), the Sec-
25 retary shall specify a MIPS adjustment factor

1 for each MIPS eligible professional for a year.
2 Such MIPS adjustment factor for a MIPS eligi-
3 ble professional for a year shall be in the form
4 of a percent and shall be determined—

5 “(i) by comparing the composite per-
6 formance score of the eligible professional
7 for such year to the performance threshold
8 established under subparagraph (D)(i) for
9 such year;

10 “(ii) in a manner such that the ad-
11 justment factors specified under this sub-
12 paragraph for a year result in differential
13 payments under this paragraph reflecting
14 that—

15 “(I) MIPS eligible professionals
16 with composite performance scores for
17 such year at or above such perform-
18 ance threshold for such year receive
19 zero or positive incentive payment ad-
20 justment factors for such year in ac-
21 cordance with clause (iii), with such
22 professionals having higher composite
23 performance scores receiving higher
24 adjustment factors; and

1 “(II) MIPS eligible professionals
2 with composite performance scores for
3 such year below such performance
4 threshold for such year receive nega-
5 tive payment adjustment factors for
6 such year in accordance with clause
7 (iv), with such professionals having
8 lower composite performance scores
9 receiving lower adjustment factors;

10 “(iii) in a manner such that MIPS eli-
11 gible professionals with composite scores
12 described in clause (ii)(I) for such year,
13 subject to clauses (i) and (ii) of subpara-
14 graph (F), receive a zero or positive ad-
15 justment factor on a linear sliding scale
16 such that an adjustment factor of 0 per-
17 cent is assigned for a score at the perform-
18 ance threshold and an adjustment factor of
19 the applicable percent specified in subpara-
20 graph (B) is assigned for a score of 100;
21 and

22 “(iv) in a manner such that—

23 “(I) subject to subclause (II),
24 MIPS eligible professionals with com-
25 posite performance scores described in

1 clause (ii)(II) for such year receive a
 2 negative payment adjustment factor
 3 on a linear sliding scale such that an
 4 adjustment factor of 0 percent is as-
 5 signed for a score at the performance
 6 threshold and an adjustment factor of
 7 the negative of the applicable percent
 8 specified in subparagraph (B) is as-
 9 signed for a score of 0; and

10 “(II) MIPS eligible professionals
 11 with composite performance scores
 12 that are equal to or greater than 0,
 13 but not greater than $\frac{1}{4}$ of the per-
 14 formance threshold specified under
 15 subparagraph (D)(i) for such year, re-
 16 ceive a negative payment adjustment
 17 factor that is equal to the negative of
 18 the applicable percent specified in
 19 subparagraph (B) for such year.

20 “(B) APPLICABLE PERCENT DEFINED.—

21 For purposes of this paragraph, the term ‘ap-
 22 plicable percent’ means—

23 “(i) for 2018, 4 percent;

24 “(ii) for 2019, 5 percent;

25 “(iii) for 2020, 7 percent; and

1 “(iv) for 2021 and subsequent years,
2 9 percent.

3 “(C) ADDITIONAL MIPS ADJUSTMENT FAC-
4 TORS FOR EXCEPTIONAL PERFORMANCE.—

5 “(i) IN GENERAL.—In the case of a
6 MIPS eligible professional with a com-
7 posite performance score for a year at or
8 above the additional performance threshold
9 under subparagraph (D)(ii) for such year,
10 in addition to the MIPS adjustment factor
11 under subparagraph (A) for the eligible
12 professional for such year, subject to the
13 availability of funds under clause (ii), the
14 Secretary shall specify an additional posi-
15 tive MIPS adjustment factor for such pro-
16 fessional and year. Such additional MIPS
17 adjustment factors shall be determined by
18 the Secretary in a manner such that pro-
19 fessionals having higher composite per-
20 formance scores above the additional per-
21 formance threshold receive higher addi-
22 tional MIPS adjustment factors.

23 “(ii) ADDITIONAL FUNDING POOL.—
24 For 2018 and each subsequent year
25 through 2023, there is appropriated from

1 the Federal Supplementary Medical Insur-
2 ance Trust Fund \$500,000,000 for MIPS
3 payments under this paragraph resulting
4 from the application of the additional
5 MIPS adjustment factors under clause (i).

6 “(D) ESTABLISHMENT OF PERFORMANCE
7 THRESHOLDS.—

8 “(i) PERFORMANCE THRESHOLD.—
9 For each year of the MIPS, the Secretary
10 shall compute a performance threshold
11 with respect to which the composite per-
12 formance score of MIPS eligible profes-
13 sionals shall be compared for purposes of
14 determining adjustment factors under sub-
15 paragraph (A) that are positive, negative,
16 and zero. Such performance threshold for
17 a year shall be the mean or median (as se-
18 lected by the Secretary) of the composite
19 performance scores for all MIPS eligible
20 professionals with respect to a prior period
21 specified by the Secretary. The Secretary
22 may reassess the selection under the pre-
23 vious sentence every 3 years.

24 “(ii) ADDITIONAL PERFORMANCE
25 THRESHOLD FOR EXCEPTIONAL PERFORM-

1 ANCE.—In addition to the performance
2 threshold under clause (i), for each year of
3 the MIPS, the Secretary shall compute an
4 additional performance threshold for pur-
5 poses of determining the additional MIPS
6 adjustment factors under subparagraph
7 (C)(i). For each such year, the Secretary
8 shall apply either of the following methods
9 for computing such additional performance
10 threshold for such a year:

11 “(I) The threshold shall be the
12 score that is equal to the 25th per-
13 centile of the range of possible com-
14 posite performance scores above the
15 performance threshold with respect to
16 the prior period described in clause
17 (i).

18 “(II) The threshold shall be the
19 score that is equal to the 25th per-
20 centile of the actual composite per-
21 formance scores for MIPS eligible
22 professionals with composite perform-
23 ance scores at or above the perform-
24 ance threshold with respect to the
25 prior period described in clause (i).

1 “(iii) SPECIAL RULE FOR INITIAL 2
2 YEARS.—With respect to each of the first
3 two years to which the MIPS applies, the
4 Secretary shall, prior to the performance
5 period for such years, establish a perform-
6 ance threshold for purposes of determining
7 MIPS adjustment factors under subpara-
8 graph (A) and a threshold for purposes of
9 determining additional MIPS adjustment
10 factors under subparagraph (C)(i). Each
11 such performance threshold shall—

12 “(I) be based on a period prior to
13 such performance periods; and

14 “(II) take into account—

15 “(aa) data available with re-
16 spect to performance on meas-
17 ures and activities that may be
18 used under the performance cat-
19 egories under subparagraph
20 (2)(B); and

21 “(bb) other factors deter-
22 mined appropriate by the Sec-
23 retary.

24 “(E) APPLICATION OF MIPS ADJUSTMENT
25 FACTORS.—In the case of items and services

1 furnished by a MIPS eligible professional dur-
 2 ing a year (beginning with 2018), the amount
 3 otherwise paid under this part with respect to
 4 such items and services and MIPS eligible pro-
 5 fessional for such year, shall be multiplied by—

6 “(i) 1, plus

7 “(ii) the sum of—

8 “(I) the MIPS adjustment factor
 9 determined under subparagraph (A)
 10 divided by 100, and

11 “(II) as applicable, the additional
 12 MIPS adjustment factor determined
 13 under subparagraph (C)(i) divided by
 14 100.

15 “(F) AGGREGATE APPLICATION OF MIPS
 16 ADJUSTMENT FACTORS.—

17 “(i) APPLICATION OF SCALING FAC-
 18 TOR.—

19 “(I) IN GENERAL.—With respect
 20 to positive MIPS adjustment factors
 21 under subparagraph (A)(ii)(I) for eli-
 22 gible professionals whose composite
 23 performance score is above the per-
 24 formance threshold under subpara-
 25 graph (D)(i) for such year, subject to

1 subclause (II), the Secretary shall in-
2 crease or decrease such adjustment
3 factors by a scaling factor in order to
4 ensure that the budget neutrality re-
5 quirement of clause (ii) is met.

6 “(II) SCALING FACTOR LIMIT.—

7 In no case may be the scaling factor
8 applied under this clause exceed 3.0.

9 “(ii) BUDGET NEUTRALITY REQUIRE-
10 MENT.—

11 “(I) IN GENERAL.—Subject to
12 clause (iii), the Secretary shall ensure
13 that the estimated amount described
14 in subclause (II) for a year is equal to
15 the estimated amount described in
16 subclause (III) for such year.

17 “(II) AGGREGATE INCREASES.—

18 The amount described in this sub-
19 clause is the estimated increase in the
20 aggregate allowed charges resulting
21 from the application of positive MIPS
22 adjustment factors under subpara-
23 graph (A) (after application of the
24 scaling factor described in clause (i))
25 to MIPS eligible professionals whose

1 composite performance score for a
2 year is above the performance thresh-
3 old under subparagraph (D)(i) for
4 such year.

5 “(III) AGGREGATE DE-
6 CREASES.—The amount described in
7 this subclause is the estimated de-
8 crease in the aggregate allowed
9 charges resulting from the application
10 of negative MIPS adjustment factors
11 under subparagraph (A) to MIPS eli-
12 gible professionals whose composite
13 performance score for a year is below
14 the performance threshold under sub-
15 paragraph (D)(i) for such year.

16 “(iii) EXCEPTIONS.—

17 “(I) In the case that all MIPS el-
18 igible professionals receive composite
19 performance scores for a year that are
20 below the performance threshold
21 under subparagraph (D)(i) for such
22 year, the negative MIPS adjustment
23 factors under subparagraph (A) shall
24 apply with respect to such MIPS eligi-
25 ble professionals and the budget neu-

1 trality requirement of clause (ii) shall
2 not apply for such year.

3 “(II) In the case that, with re-
4 spect to a year, the application of
5 clause (i) results in a scaling factor
6 equal to the maximum scaling factor
7 specified in clause (i)(II), such scaling
8 factor shall apply and the budget neu-
9 trality requirement of clause (ii) shall
10 not apply for such year.

11 “(iv) ADDITIONAL INCENTIVE PAY-
12 MENT ADJUSTMENTS.—In specifying the
13 MIPS additional adjustment factors under
14 subparagraph (C)(i) for each applicable
15 MIPS eligible professional for a year, the
16 Secretary shall ensure that the estimated
17 increase in payments under this part re-
18 sulting from the application of such addi-
19 tional adjustment factors for MIPS eligible
20 professionals in a year shall be equal (as
21 estimated by the Secretary) to the addi-
22 tional funding pool amount for such year
23 under subparagraph (C)(ii).

24 “(7) ANNOUNCEMENT OF RESULT OF ADJUST-
25 MENTS.—Under the MIPS, the Secretary shall, not

1 later than 30 days prior to January 1 of the year
2 involved, make available to MIPS eligible profes-
3 sionals the MIPS adjustment factor (and, as appli-
4 cable, the additional MIPS adjustment factor) under
5 paragraph (6) applicable to the eligible professional
6 for items and services furnished by the professional
7 for such year. The Secretary may include such infor-
8 mation in the confidential feedback under paragraph
9 (12).

10 “(8) NO EFFECT IN SUBSEQUENT YEARS.—The
11 MIPS adjustment factors and additional MIPS ad-
12 justment factors under paragraph (6) shall apply
13 only with respect to the year involved, and the Sec-
14 retary shall not take into account such adjustment
15 factors in making payments to a MIPS eligible pro-
16 fessional under this part in a subsequent year.

17 “(9) PUBLIC REPORTING.—

18 “(A) IN GENERAL.—The Secretary shall,
19 in an easily understandable format, make avail-
20 able on the Physician Compare Internet website
21 of the Centers for Medicare & Medicaid Serv-
22 ices the following:

23 “(i) Information regarding the per-
24 formance of MIPS eligible professionals
25 under the MIPS, which—

1 “(I) shall include the composite
2 score for each such MIPS eligible pro-
3 fessional and the performance of each
4 such MIPS eligible professional with
5 respect to each performance category;
6 and

7 “(II) may include the perform-
8 ance of each such MIPS eligible pro-
9 fessional with respect to each measure
10 or activity specified in paragraph
11 (2)(B).

12 “(ii) The names of eligible profes-
13 sionals in eligible alternative payment mod-
14 els (as defined in section 1833(z)(3)(D))
15 and, to the extent feasible, the names of
16 such eligible alternative payment models
17 and performance of such models.

18 “(B) DISCLOSURE.—The information
19 made available under this paragraph shall indi-
20 cate, where appropriate, that publicized infor-
21 mation may not be representative of the eligible
22 professional’s entire patient population, the va-
23 riety of services furnished by the eligible profes-
24 sional, or the health conditions of individuals
25 treated.

1 “(C) OPPORTUNITY TO REVIEW AND SUB-
2 MIT CORRECTIONS.—The Secretary shall pro-
3 vide for an opportunity for a professional de-
4 scribed in subparagraph (A) to review, and sub-
5 mit corrections for, the information to be made
6 public with respect to the professional under
7 such subparagraph prior to such information
8 being made public.

9 “(D) AGGREGATE INFORMATION.—The
10 Secretary shall periodically post on the Physi-
11 cian Compare Internet website aggregate infor-
12 mation on the MIPS, including the range of
13 composite scores for all MIPS eligible profes-
14 sionals and the range of the performance of all
15 MIPS eligible professionals with respect to each
16 performance category.

17 “(10) CONSULTATION.—The Secretary shall
18 consult with stakeholders in carrying out the MIPS,
19 including for the identification of measures and ac-
20 tivities under paragraph (2)(B) and the methodolo-
21 gies developed under paragraphs (5)(A) and (6) and
22 regarding the use of qualified clinical data registries.
23 Such consultation shall include the use of a request
24 for information or other mechanisms determined ap-
25 propriate.

1 “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-
2 TICES AND PRACTICES IN HEALTH PROFESSIONAL
3 SHORTAGE AREAS.—

4 “(A) IN GENERAL.—The Secretary shall
5 enter into contracts or agreements with appro-
6 priate entities (such as quality improvement or-
7 ganizations, regional extension centers (as de-
8 scribed in section 3012(c) of the Public Health
9 Service Act), or regional health collaboratives)
10 to offer guidance and assistance to MIPS eligi-
11 ble professionals in practices of 15 or fewer pro-
12 fessionals (with priority given to such practices
13 located in rural areas, health professional short-
14 age areas (as designated under in section
15 332(a)(1)(A) of such Act), and medically under-
16 served areas, and practices with low composite
17 scores) with respect to—

18 “(i) the performance categories de-
19 scribed in clauses (i) through (iv) of para-
20 graph (2)(A); or

21 “(ii) how to transition to the imple-
22 mentation of and participation in an alter-
23 native payment model as described in sec-
24 tion 1833(z)(3)(C).

25 “(B) FUNDING FOR IMPLEMENTATION.—

1 “(i) IN GENERAL.—For purposes of
 2 implementing subparagraph (A), the Sec-
 3 retary shall provide for the transfer from
 4 the Federal Supplementary Medical Insur-
 5 ance Trust Fund established under section
 6 1841 to the Centers for Medicare & Med-
 7 icaid Services Program Management Ac-
 8 count of \$40,000,000 for each of fiscal
 9 years 2015 through 2019. Amounts trans-
 10 ferred under this subparagraph for a fiscal
 11 year shall be available until expended.

12 “(ii) TECHNICAL ASSISTANCE.—Of
 13 the amounts transferred pursuant to clause
 14 (i) for each of fiscal years 2015 through
 15 2019, not less than \$10,000,000 shall be
 16 made available for each such year for tech-
 17 nical assistance to small practices in health
 18 professional shortage areas (as so des-
 19 ignated) and medically underserved areas.

20 “(12) FEEDBACK AND INFORMATION TO IM-
 21 PROVE PERFORMANCE.—

22 “(A) PERFORMANCE FEEDBACK.—

23 “(i) IN GENERAL.—Beginning July 1,
 24 2016, the Secretary—

1 “(I) shall make available timely
2 (such as quarterly) confidential feed-
3 back to MIPS eligible professionals on
4 the performance of such professionals
5 with respect to the performance cat-
6 egories under clauses (i) and (ii) of
7 paragraph (2)(A); and

8 “(II) may make available con-
9 fidential feedback to each such profes-
10 sional on the performance of such
11 professional with respect to the per-
12 formance categories under clauses (iii)
13 and (iv) of such paragraph.

14 “(ii) MECHANISMS.—The Secretary
15 may use one or more mechanisms to make
16 feedback available under clause (i), which
17 may include use of a web-based portal or
18 other mechanisms determined appropriate
19 by the Secretary. With respect to the per-
20 formance category described in paragraph
21 (2)(A)(i), feedback under this subpara-
22 graph shall, to the extent an eligible pro-
23 fessional chooses to participate in a data
24 registry for purposes of this subsection (in-
25 cluding registries under subsections (k)

1 and (m)), be provided based on perform-
2 ance on quality measures reported through
3 the use of such registries. With respect to
4 any other performance category described
5 in paragraph (2)(A), the Secretary shall
6 encourage provision of feedback through
7 qualified clinical data registries as de-
8 scribed in subsection (m)(3)(E)).

9 “(iii) USE OF DATA.—For purposes of
10 clause (i), the Secretary may use data,
11 with respect to a MIPS eligible profes-
12 sional, from periods prior to the current
13 performance period and may use rolling
14 periods in order to make illustrative cal-
15 culations about the performance of such
16 professional.

17 “(iv) DISCLOSURE EXEMPTION.—
18 Feedback made available under this sub-
19 paragraph shall be exempt from disclosure
20 under section 552 of title 5, United States
21 Code.

22 “(v) RECEIPT OF INFORMATION.—
23 The Secretary may use the mechanisms es-
24 tablished under clause (ii) to receive infor-

1 information from professionals, such as infor-
2 mation with respect to this subsection.

3 “(B) ADDITIONAL INFORMATION.—

4 “(i) IN GENERAL.—Beginning July 1,
5 2017, the Secretary shall make available to
6 each MIPS eligible professional informa-
7 tion, with respect to individuals who are
8 patients of such MIPS eligible professional,
9 about items and services for which pay-
10 ment is made under this title that are fur-
11 nished to such individuals by other sup-
12 pliers and providers of services, which may
13 include information described in clause (ii).
14 Such information may be made available
15 under the previous sentence to such MIPS
16 eligible professionals by mechanisms deter-
17 mined appropriate by the Secretary, which
18 may include use of a web-based portal.
19 Such information may be made available in
20 accordance with the same or similar terms
21 as data are made available to accountable
22 care organizations participating in the
23 shared savings program under section
24 1899, including a beneficiary opt-out.

1 “(ii) TYPE OF INFORMATION.—For
2 purposes of clause (i), the information de-
3 scribed in this clause, is the following:

4 “(I) With respect to selected
5 items and services (as determined ap-
6 propriate by the Secretary) for which
7 payment is made under this title and
8 that are furnished to individuals, who
9 are patients of a MIPS eligible profes-
10 sional, by another supplier or provider
11 of services during the most recent pe-
12 riod for which data are available (such
13 as the most recent three-month pe-
14 riod), such as the name of such pro-
15 viders furnishing such items and serv-
16 ices to such patients during such pe-
17 riod, the types of such items and serv-
18 ices so furnished, and the dates such
19 items and services were so furnished.

20 “(II) Historical data, such as
21 averages and other measures of the
22 distribution if appropriate, of the
23 total, and components of, allowed
24 charges (and other figures as deter-
25 mined appropriate by the Secretary).

1 “(13) REVIEW.—

2 “(A) TARGETED REVIEW.—The Secretary
3 shall establish a process under which a MIPS
4 eligible professional may seek an informal re-
5 view of the calculation of the MIPS adjustment
6 factor applicable to such eligible professional
7 under this subsection for a year. The results of
8 a review conducted pursuant to the previous
9 sentence shall not be taken into account for
10 purposes of paragraph (6) with respect to a
11 year (other than with respect to the calculation
12 of such eligible professional’s MIPS adjustment
13 factor for such year or additional MIPS adjust-
14 ment factor for such year) after the factors de-
15 termined in subparagraph (A) and subpara-
16 graph (C) of such paragraph have been deter-
17 mined for such year.

18 “(B) LIMITATION.—Except as provided for
19 in subparagraph (A), there shall be no adminis-
20 trative or judicial review under section 1869,
21 section 1878, or otherwise of the following:

22 “(i) The methodology used to deter-
23 mine the amount of the MIPS adjustment
24 factor under paragraph (6)(A) and the
25 amount of the additional MIPS adjustment

1 factor under paragraph (6)(C)(i) and the
2 determination of such amounts.

3 “(ii) The establishment of the per-
4 formance standards under paragraph (3)
5 and the performance period under para-
6 graph (4).

7 “(iii) The identification of measures
8 and activities specified under paragraph
9 (2)(B) and information made public or
10 posted on the Physician Compare Internet
11 website of the Centers for Medicare &
12 Medicaid Services under paragraph (9).

13 “(iv) The methodology developed
14 under paragraph (5) that is used to cal-
15 culate performance scores and the calcula-
16 tion of such scores, including the weighting
17 of measures and activities under such
18 methodology.”.

19 (2) GAO REPORTS.—

20 (A) EVALUATION OF ELIGIBLE PROFES-
21 SIONAL MIPS.—Not later than October 1, 2019,
22 and October 1, 2022, the Comptroller General
23 of the United States shall submit to Congress
24 a report evaluating the eligible professional
25 Merit-based Incentive Payment System under

1 subsection (q) of section 1848 of the Social Se-
2 curity Act (42 U.S.C. 1395w-4), as added by
3 paragraph (1). Such report shall—

4 (i) examine the distribution of the
5 composite performance scores and MIPS
6 adjustment factors (and additional MIPS
7 adjustment factors) for MIPS eligible pro-
8 fessionals (as defined in subsection
9 (q)(1)(c) of such section) under such pro-
10 gram, and patterns relating to such scores
11 and adjustment factors, including based on
12 type of provider, practice size, geographic
13 location, and patient mix;

14 (ii) provide recommendations for im-
15 proving such program;

16 (iii) evaluate the impact of technical
17 assistance funding under section
18 1848(q)(11) of the Social Security Act, as
19 added by paragraph (1), on the ability of
20 professionals to improve within such pro-
21 gram or successfully transition to an alter-
22 native payment model (as defined in sec-
23 tion 1833(z)(3) of the Social Security Act,
24 as added by subsection (e)), with priority
25 for such evaluation given to practices lo-

1 cated in rural areas, health professional
2 shortage areas (as designated in section
3 332(a)(1)(a) of the Public Health Service
4 Act), and medically underserved areas; and

5 (iv) provide recommendations for opti-
6 mizing the use of such technical assistance
7 funds.

8 (B) STUDY TO EXAMINE ALIGNMENT OF
9 QUALITY MEASURES USED IN PUBLIC AND PRI-
10 VATE PROGRAMS.—

11 (i) IN GENERAL.—Not later than 18
12 months after the date of the enactment of
13 this Act, the Comptroller General of the
14 United States shall submit to Congress a
15 report that—

16 (I) compares the similarities and
17 differences in the use of quality meas-
18 ures under the original Medicare fee-
19 for-service program under parts A and
20 B of title XVIII of the Social Security
21 Act, the Medicare Advantage program
22 under part C of such title, selected
23 State Medicaid programs under title
24 XIX of such Act, and private payer
25 arrangements; and

1 (II) makes recommendations on
2 how to reduce the administrative bur-
3 den involved in applying such quality
4 measures.

5 (ii) REQUIREMENTS.—The report
6 under clause (i) shall—

7 (I) consider those measures ap-
8 plicable to individuals entitled to, or
9 enrolled for, benefits under such part
10 A, or enrolled under such part B and
11 individuals under the age of 65; and

12 (II) focus on those measures that
13 comprise the most significant compo-
14 nent of the quality performance cat-
15 egory of the eligible professional
16 MIPS incentive program under sub-
17 section (q) of section 1848 of the So-
18 cial Security Act (42 U.S.C. 1395w-
19 4), as added by paragraph (1).

20 (C) STUDY ON ROLE OF INDEPENDENT
21 RISK MANAGERS.—Not later than January 1,
22 2016, the Comptroller General of the United
23 States shall submit to Congress a report exam-
24 ining whether entities that pool financial risk
25 for physician practices, such as independent

1 risk managers, can play a role in supporting
2 physician practices, particularly small physician
3 practices, in assuming financial risk for the
4 treatment of patients. Such report shall exam-
5 ine barriers that small physician practices cur-
6 rently face in assuming financial risk for treat-
7 ing patients, the types of risk management enti-
8 ties that could assist physician practices in par-
9 ticipating in two-sided risk payment models,
10 and how such entities could assist with risk
11 management and with quality improvement ac-
12 tivities. Such report shall also include an anal-
13 ysis of any existing legal barriers to such ar-
14 rangements.

15 (D) STUDY TO EXAMINE RURAL AND
16 HEALTH PROFESSIONAL SHORTAGE AREA AL-
17 TERNATIVE PAYMENT MODELS.—Not later than
18 October 1, 2020, and October 1, 2022, the
19 Comptroller General of the United States shall
20 submit to Congress a report that examines the
21 transition of professionals in rural areas, health
22 professional shortage areas (as designated in
23 section 332(a)(1)(A) of the Public Health Serv-
24 ice Act), or medically underserved areas to an
25 alternative payment model (as defined in sec-

1 tion 1833(z)(3) of the Social Security Act, as
2 added by subsection (e)). Such report shall
3 make recommendations for removing adminis-
4 trative barriers to practices, including small
5 practices consisting of 15 or fewer profes-
6 sionals, in rural areas, health professional
7 shortage areas, and medically underserved areas
8 to participation in such models.

9 (3) FUNDING FOR IMPLEMENTATION.—For
10 purposes of implementing the provisions of and the
11 amendments made by this section, the Secretary of
12 Health and Human Services shall provide for the
13 transfer of \$80,000,000 from the Supplementary
14 Medical Insurance Trust Fund established under
15 section 1841 of the Social Security Act (42 U.S.C.
16 1395t) to the Centers for Medicare & Medicaid Pro-
17 gram Management Account for each of the fiscal
18 years 2014 through 2018. Amounts transferred
19 under this paragraph shall be available until ex-
20 pended.

21 (d) IMPROVING QUALITY REPORTING FOR COM-
22 POSITE SCORES.—

23 (1) CHANGES FOR GROUP REPORTING OP-
24 TION.—

1 (A) IN GENERAL.—Section
2 1848(m)(3)(C)(ii) of the Social Security Act
3 (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended
4 by inserting “and, for 2015 and subsequent
5 years, may provide” after “shall provide”.

6 (B) CLARIFICATION OF QUALIFIED CLIN-
7 ICAL DATA REGISTRY REPORTING TO GROUP
8 PRACTICES.—Section 1848(m)(3)(D) of the So-
9 cial Security Act (42 U.S.C. 1395w–
10 4(m)(3)(D)) is amended by inserting “and, for
11 2015 and subsequent years, subparagraph (A)
12 or (C)” after “subparagraph (A)”.

13 (2) CHANGES FOR MULTIPLE REPORTING PERI-
14 ODS AND ALTERNATIVE CRITERIA FOR SATISFAC-
15 TORY REPORTING.—Section 1848(m)(5)(F) of the
16 Social Security Act (42 U.S.C. 1395w–4(m)(5)(F))
17 is amended—

18 (A) by striking “and subsequent years”
19 and inserting “through reporting periods occur-
20 ring in 2014”; and

21 (B) by inserting “and, for reporting peri-
22 ods occurring in 2015 and subsequent years,
23 the Secretary may establish” following “shall
24 establish”.

1 (3) PHYSICIAN FEEDBACK PROGRAM REPORTS
2 SUCCEEDED BY REPORTS UNDER MIPS.—Section
3 1848(n) of the Social Security Act (42 U.S.C.
4 1395w–4(n)) is amended by adding at the end the
5 following new paragraph:

6 “(11) REPORTS ENDING WITH 2016.—Reports
7 under the Program shall not be provided after De-
8 cember 31, 2016. See subsection (q)(12) for reports
9 under the eligible professionals Merit-based Incentive
10 Payment System.”.

11 (4) COORDINATION WITH SATISFYING MEANING-
12 FUL EHR USE CLINICAL QUALITY MEASURE REPORT-
13 ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of
14 the Social Security Act (42 U.S.C. 1395w–
15 4(o)(2)(A)(iii)) is amended by inserting “and sub-
16 section (q)(5)(B)(ii)(II)” after “Subject to subpara-
17 graph (B)(ii)”.

18 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

19 (1) INCREASING TRANSPARENCY OF PHYSICIAN
20 FOCUSED PAYMENT MODELS.—Section 1868 of the
21 Social Security Act (42 U.S.C. 1395ee) is amended
22 by adding at the end the following new subsection:

23 “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

24 “(1) TECHNICAL ADVISORY COMMITTEE.—

1 “(A) ESTABLISHMENT.—There is estab-
2 lished an ad hoc committee to be known as the
3 ‘Payment Model Technical Advisory Committee’
4 (referred to in this subsection as the ‘Com-
5 mittee’).

6 “(B) MEMBERSHIP.—

7 “(i) NUMBER AND APPOINTMENT.—
8 The Committee shall be composed of 11
9 members appointed by the Comptroller
10 General of the United States.

11 “(ii) QUALIFICATIONS.—The member-
12 ship of the Committee shall include indi-
13 viduals with national recognition for their
14 expertise in payment models and related
15 delivery of care. No more than 5 members
16 of the Committee shall be providers of
17 services or suppliers, or representatives of
18 providers of services or suppliers.

19 “(iii) PROHIBITION ON FEDERAL EM-
20 PLOYMENT.—A member of the Committee
21 shall not be an employee of the Federal
22 Government.

23 “(iv) ETHICS DISCLOSURE.—The
24 Comptroller General shall establish a sys-
25 tem for public disclosure by members of

1 the Committee of financial and other po-
2 tential conflicts of interest relating to such
3 members. Members of the Committee shall
4 be treated as employees of Congress for
5 purposes of applying title I of the Ethics
6 in Government Act of 1978 (Public Law
7 95–521).

8 “(v) DATE OF INITIAL APPOINT-
9 MENTS.—The initial appointments of mem-
10 bers of the Committee shall be made by
11 not later than 180 days after the date of
12 enactment of this subsection.

13 “(C) TERM; VACANCIES.—

14 “(i) TERM.—The terms of members of
15 the Committee shall be for 3 years except
16 that the Comptroller General shall des-
17 ignate staggered terms for the members
18 first appointed.

19 “(ii) VACANCIES.—Any member ap-
20 pointed to fill a vacancy occurring before
21 the expiration of the term for which the
22 member’s predecessor was appointed shall
23 be appointed only for the remainder of that
24 term. A member may serve after the expi-
25 ration of that member’s term until a suc-

1 cessor has taken office. A vacancy in the
2 Committee shall be filled in the manner in
3 which the original appointment was made.

4 “(D) DUTIES.—The Committee shall meet,
5 as needed, to provide comments and rec-
6 ommendations to the Secretary, as described in
7 paragraph (2)(C), on physician-focused pay-
8 ment models.

9 “(E) COMPENSATION OF MEMBERS.—

10 “(i) IN GENERAL.—Except as pro-
11 vided in clause (ii), a member of the Com-
12 mittee shall serve without compensation.

13 “(ii) TRAVEL EXPENSES.—A member
14 of the Committee shall be allowed travel
15 expenses, including per diem in lieu of sub-
16 sistence, at rates authorized for an em-
17 ployee of an agency under subchapter I of
18 chapter 57 of title 5, United States Code,
19 while away from the home or regular place
20 of business of the member in the perform-
21 ance of the duties of the Committee.

22 “(F) OPERATIONAL AND TECHNICAL SUP-
23 PORT.—

24 “(i) IN GENERAL.—The Assistant
25 Secretary for Planning and Evaluation

1 shall provide technical and operational sup-
2 port for the Committee, which may be by
3 use of a contractor. The Office of the Ac-
4 tuary of the Centers for Medicare & Med-
5 icaid Services shall provide to the Com-
6 mittee actuarial assistance as needed.

7 “(ii) FUNDING.—The Secretary shall
8 provide for the transfer, from the Federal
9 Supplementary Medical Insurance Trust
10 Fund under section 1841, such amounts as
11 are necessary to carry out clause (i) (not
12 to exceed \$5,000,000) for fiscal year 2014
13 and each subsequent fiscal year. Any
14 amounts transferred under the preceding
15 sentence for a fiscal year shall remain
16 available until expended.

17 “(G) APPLICATION.—Section 14 of the
18 Federal Advisory Committee Act (5 U.S.C.
19 App.) shall not apply to the Committee.

20 “(2) CRITERIA AND PROCESS FOR SUBMISSION
21 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT
22 MODELS.—

23 “(A) CRITERIA FOR ASSESSING PHYSICIAN-
24 FOCUSED PAYMENT MODELS.—

1 “(i) RULEMAKING.—Not later than
2 November 1, 2015, the Secretary shall,
3 through notice and comment rulemaking,
4 following a request for information, estab-
5 lish criteria for physician-focused payment
6 models, including models for specialist phy-
7 sicians, that could be used by the Com-
8 mittee for making comments and rec-
9 ommendations pursuant to paragraph
10 (1)(D).

11 “(ii) MEDPAC SUBMISSION OF COM-
12 MENTS.—During the comment period for
13 the proposed rule described in clause (i),
14 the Medicare Payment Advisory Commis-
15 sion may submit comments to the Sec-
16 retary on the proposed criteria under such
17 clause.

18 “(iii) UPDATING.—The Secretary may
19 update the criteria established under this
20 subparagraph through rulemaking.

21 “(B) STAKEHOLDER SUBMISSION OF PHY-
22 SICIAN FOCUSED PAYMENT MODELS.—On an
23 ongoing basis, individuals and stakeholder enti-
24 ties may submit to the Committee proposals for
25 physician-focused payment models that such in-

1 dividuals and entities believe meet the criteria
2 described in subparagraph (A).

3 “(C) TAC REVIEW OF MODELS SUB-
4 MITTED.—The Committee shall, on a periodic
5 basis, review models submitted under subpara-
6 graph (B), prepare comments and recommenda-
7 tions regarding whether such models meet the
8 criteria described in subparagraph (A), and
9 submit such comments and recommendations to
10 the Secretary.

11 “(D) SECRETARY REVIEW AND RE-
12 SPONSE.—The Secretary shall review the com-
13 ments and recommendations submitted by the
14 Committee under subparagraph (C) and post a
15 detailed response to such comments and rec-
16 ommendations on the Internet Website of the
17 Centers for Medicare & Medicaid Services.

18 “(3) RULE OF CONSTRUCTION.—Nothing in
19 this subsection shall be construed to impact the de-
20 velopment or testing of models under this title or ti-
21 tles XI, XIX, or XXI.”.

22 (2) INCENTIVE PAYMENTS FOR PARTICIPATION
23 IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—
24 Section 1833 of the Social Security Act (42 U.S.C.

1 1395l) is amended by adding at the end the fol-
2 lowing new subsection:

3 “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN
4 ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

5 “(1) PAYMENT INCENTIVE.—

6 “(A) IN GENERAL.—In the case of covered
7 professional services furnished by an eligible
8 professional during a year that is in the period
9 beginning with 2018 and ending with 2023 and
10 for which the professional is a qualifying APM
11 participant, in addition to the amount of pay-
12 ment that would otherwise be made for such
13 covered professional services under this part for
14 such year, there also shall be paid to such pro-
15 fessional an amount equal to 5 percent of the
16 payment amount for the covered professional
17 services under this part for the preceding year.
18 For purposes of the previous sentence, the pay-
19 ment amount for the preceding year may be an
20 estimation for the full preceding year based on
21 a period of such preceding year that is less than
22 the full year. The Secretary shall establish poli-
23 cies to implement this subparagraph in cases
24 where payment for covered professional services
25 furnished by a qualifying APM participant in

1 an alternative payment model is made to an en-
2 tity participating in the alternative payment
3 model rather than directly to the qualifying
4 APM participant.

5 “(B) FORM OF PAYMENT.—Payments
6 under this subsection shall be made in a lump
7 sum, on an annual basis, as soon as practicable.

8 “(C) TREATMENT OF PAYMENT INCEN-
9 TIVE.—Payments under this subsection shall
10 not be taken into account for purposes of deter-
11 mining actual expenditures under an alternative
12 payment model and for purposes of determining
13 or rebasing any benchmarks used under the al-
14 ternative payment model.

15 “(D) COORDINATION.—The amount of the
16 additional payment for an item or service under
17 this subsection or subsection (m) shall be deter-
18 mined without regard to any additional pay-
19 ment for the item or service under subsection
20 (m) and this subsection, respectively. The
21 amount of the additional payment for an item
22 or service under this subsection or subsection
23 (x) shall be determined without regard to any
24 additional payment for the item or service
25 under subsection (x) and this subsection, re-

1 spectively. The amount of the additional pay-
2 ment for an item or service under this sub-
3 section or subsection (y) shall be determined
4 without regard to any additional payment for
5 the item or service under subsection (y) and
6 this subsection, respectively.

7 “(2) QUALIFYING APM PARTICIPANT.—For pur-
8 poses of this subsection, the term ‘qualifying APM
9 participant’ means the following:

10 “(A) 2018 AND 2019.—With respect to
11 2018 and 2019, an eligible professional for
12 whom the Secretary determines that at least 25
13 percent of payments under this part for covered
14 professional services furnished by such profes-
15 sional during the most recent period for which
16 data are available (which may be less than a
17 year) were attributable to such services fur-
18 nished under this part through an entity that
19 participates in an eligible alternative payment
20 model with respect to such services.

21 “(B) 2020 AND 2021.—With respect to
22 2020 and 2021, an eligible professional de-
23 scribed in either of the following clauses:

24 “(i) MEDICARE REVENUE THRESHOLD
25 OPTION.—An eligible professional for

1 whom the Secretary determines that at
2 least 50 percent of payments under this
3 part for covered professional services fur-
4 nished by such professional during the
5 most recent period for which data are
6 available (which may be less than a year)
7 were attributable to such services furnished
8 under this part through an entity that par-
9 ticipates in an eligible alternative payment
10 model with respect to such services.

11 “(ii) COMBINATION ALL-PAYER AND
12 MEDICARE REVENUE THRESHOLD OP-
13 TION.—An eligible professional—

14 “(I) for whom the Secretary de-
15 termines, with respect to items and
16 services furnished by such professional
17 during the most recent period for
18 which data are available (which may
19 be less than a year), that at least 50
20 percent of the sum of—

21 “(aa) payments described in
22 clause (i); and

23 “(bb) all other payments, re-
24 gardless of payer (other than
25 payments made by the Secretary

1 of Defense or the Secretary of
2 Veterans Affairs under chapter
3 55 of title 10, United States
4 Code, or title 38, United States
5 Code, or any other provision of
6 law, and other than payments
7 made under title XIX in a State
8 in which no medical home or al-
9 ternative payment model is avail-
10 able under the State program
11 under that title),

12 meet the requirement described in
13 clause (iii)(I) with respect to pay-
14 ments described in item (aa) and meet
15 the requirement described in clause
16 (iii)(II) with respect to payments de-
17 scribed in item (bb);

18 “(II) for whom the Secretary de-
19 termines at least 25 percent of pay-
20 ments under this part for covered pro-
21 fessional services furnished by such
22 professional during the most recent
23 period for which data are available
24 (which may be less than a year) were
25 attributable to such services furnished

1 under this part through an entity that
2 participates in an eligible alternative
3 payment model with respect to such
4 services; and

5 “(III) who provides to the Sec-
6 retary such information as is nec-
7 essary for the Secretary to make a de-
8 termination under subclause (I), with
9 respect to such professional.

10 “(iii) REQUIREMENT.—For purposes
11 of clause (ii)(I)—

12 “(I) the requirement described in
13 this subclause, with respect to pay-
14 ments described in item (aa) of such
15 clause, is that such payments are
16 made under an eligible alternative
17 payment model; and

18 “(II) the requirement described
19 in this subclause, with respect to pay-
20 ments described in item (bb) of such
21 clause, is that such payments are
22 made under an arrangement in
23 which—

24 “(aa) quality measures com-
25 parable to measures under the

1 performance category described
2 in section 1848(q)(2)(B)(i) apply;

3 “(bb) certified EHR tech-
4 nology is used; and

5 “(cc) the eligible profes-
6 sional (AA) bears more than
7 nominal financial risk if actual
8 aggregate expenditures exceeds
9 expected aggregate expenditures;
10 or (BB) is a medical home (with
11 respect to beneficiaries under
12 title XIX) that meets criteria
13 comparable to medical homes ex-
14 panded under section 1115A(c).

15 “(C) BEGINNING IN 2022.—With respect to
16 2022 and each subsequent year, an eligible pro-
17 fessional described in either of the following
18 clauses:

19 “(i) MEDICARE REVENUE THRESHOLD
20 OPTION.—An eligible professional for
21 whom the Secretary determines that at
22 least 75 percent of payments under this
23 part for covered professional services fur-
24 nished by such professional during the
25 most recent period for which data are

1 available (which may be less than a year)
2 were attributable to such services furnished
3 under this part through an entity that par-
4 ticipates in an eligible alternative payment
5 model with respect to such services.

6 “(ii) COMBINATION ALL-PAYER AND
7 MEDICARE REVENUE THRESHOLD OP-
8 TION.—An eligible professional—

9 “(I) for whom the Secretary de-
10 termines, with respect to items and
11 services furnished by such professional
12 during the most recent period for
13 which data are available (which may
14 be less than a year), that at least 75
15 percent of the sum of—

16 “(aa) payments described in
17 clause (i); and

18 “(bb) all other payments, re-
19 gardless of payer (other than
20 payments made by the Secretary
21 of Defense or the Secretary of
22 Veterans Affairs under chapter
23 55 of title 10, United States
24 Code, or title 38, United States
25 Code, or any other provision of

1 law, and other than payments
2 made under title XIX in a State
3 in which no medical home or al-
4 ternative payment model is avail-
5 able under the State program
6 under that title),

7 meet the requirement described in
8 clause (iii)(I) with respect to pay-
9 ments described in item (aa) and meet
10 the requirement described in clause
11 (iii)(II) with respect to payments de-
12 scribed in item (bb);

13 “(II) for whom the Secretary de-
14 termines at least 25 percent of pay-
15 ments under this part for covered pro-
16 fessional services furnished by such
17 professional during the most recent
18 period for which data are available
19 (which may be less than a year) were
20 attributable to such services furnished
21 under this part through an entity that
22 participates in an eligible alternative
23 payment model with respect to such
24 services; and

1 “(III) who provides to the Sec-
2 retary such information as is nec-
3 essary for the Secretary to make a de-
4 termination under subclause (I), with
5 respect to such professional.

6 “(iii) REQUIREMENT.—For purposes
7 of clause (ii)(I)—

8 “(I) the requirement described in
9 this subclause, with respect to pay-
10 ments described in item (aa) of such
11 clause, is that such payments are
12 made under an eligible alternative
13 payment model; and

14 “(II) the requirement described
15 in this subclause, with respect to pay-
16 ments described in item (bb) of such
17 clause, is that such payments are
18 made under an arrangement in
19 which—

20 “(aa) quality measures com-
21 parable to measures under the
22 performance category described
23 in section 1848(q)(2)(B)(i) apply;

24 “(bb) certified EHR tech-
25 nology is used; and

1 “(cc) the eligible profes-
2 sional (AA) bears more than
3 nominal financial risk if actual
4 aggregate expenditures exceeds
5 expected aggregate expenditures;
6 or (BB) is a medical home (with
7 respect to beneficiaries under
8 title XIX) that meets criteria
9 comparable to medical homes ex-
10 panded under section 1115A(c).

11 “(3) ADDITIONAL DEFINITIONS.—In this sub-
12 section:

13 “(A) COVERED PROFESSIONAL SERV-
14 ICES.—The term ‘covered professional services’
15 has the meaning given that term in section
16 1848(k)(3)(A).

17 “(B) ELIGIBLE PROFESSIONAL.—The term
18 ‘eligible professional’ has the meaning given
19 that term in section 1848(k)(3)(B).

20 “(C) ALTERNATIVE PAYMENT MODEL
21 (APM).—The term ‘alternative payment model’
22 means any of the following:

23 “(i) A model under section 1115A
24 (other than a health care innovation
25 award).

1 “(ii) The shared savings program
2 under section 1899.

3 “(iii) A demonstration under section
4 1866C.

5 “(iv) A demonstration required by
6 Federal law.

7 “(D) ELIGIBLE ALTERNATIVE PAYMENT
8 MODEL (APM).—

9 “(i) IN GENERAL.—The term ‘eligible
10 alternative payment model’ means, with re-
11 spect to a year, an alternative payment
12 model—

13 “(I) that requires use of certified
14 EHR technology (as defined in sub-
15 section (o)(4));

16 “(II) that provides for payment
17 for covered professional services based
18 on quality measures comparable to
19 measures under the performance cat-
20 egory described in section
21 1848(q)(2)(B)(i); and

22 “(III) that satisfies the require-
23 ment described in clause (ii).

24 “(ii) ADDITIONAL REQUIREMENT.—
25 For purposes of clause (i)(III), the require-

1 ment described in this clause, with respect
2 to a year and an alternative payment
3 model, is that the alternative payment
4 model—

5 “(I) is one in which one or more
6 entities bear financial risk for mone-
7 tary losses under such model that are
8 in excess of a nominal amount; or

9 “(II) is a medical home expanded
10 under section 1115A(c).

11 “(4) LIMITATION.—There shall be no adminis-
12 trative or judicial review under section 1869, 1878,
13 or otherwise, of the following:

14 “(A) The determination that an eligible
15 professional is a qualifying APM participant
16 under paragraph (2) and the determination
17 that an alternative payment model is an eligible
18 alternative payment model under paragraph
19 (3)(D).

20 “(B) The determination of the amount of
21 the 5 percent payment incentive under para-
22 graph (1)(A), including any estimation as part
23 of such determination.”.

1 (3) COORDINATION CONFORMING AMEND-
2 MENTS.—Section 1833 of the Social Security Act
3 (42 U.S.C. 1395l) is further amended—

4 (A) in subsection (x)(3), by adding at the
5 end the following new sentence: “The amount
6 of the additional payment for a service under
7 this subsection and subsection (z) shall be de-
8 termined without regard to any additional pay-
9 ment for the service under subsection (z) and
10 this subsection, respectively.”; and

11 (B) in subsection (y)(3), by adding at the
12 end the following new sentence: “The amount
13 of the additional payment for a service under
14 this subsection and subsection (z) shall be de-
15 termined without regard to any additional pay-
16 ment for the service under subsection (z) and
17 this subsection, respectively.”.

18 (4) ENCOURAGING DEVELOPMENT AND TEST-
19 ING OF CERTAIN MODELS.—Section 1115A(b)(2) of
20 the Social Security Act (42 U.S.C. 1315a(b)(2)) is
21 amended—

22 (A) in subparagraph (B), by adding at the
23 end the following new clauses:

24 “(xxi) Focusing primarily on physi-
25 cians’ services (as defined in section

1 1848(j)(3)) furnished by physicians who
2 are not primary care practitioners.

3 “(xxii) Focusing on practices of 15 or
4 fewer professionals.

5 “(xxiii) Focusing on risk-based models
6 for small physician practices which may in-
7 volve two-sided risk and prospective patient
8 assignment, and which examine risk-ad-
9 justed decreases in mortality rates, hos-
10 pital readmissions rates, and other relevant
11 and appropriate clinical measures.

12 “(xxiv) Focusing primarily on title
13 XIX, working in conjunction with the Cen-
14 ter for Medicaid and CHIP Services.”; and
15 (B) in subparagraph (C)(viii), by striking
16 “other public sector or private sector payers”
17 and inserting “other public sector payers, pri-
18 vate sector payers, or Statewide payment mod-
19 els”.

20 (5) CONSTRUCTION REGARDING TELEHEALTH
21 SERVICES.—Nothing in the provisions of, or amend-
22 ments made by, this Act shall be construed as pre-
23 cluding an alternative payment model or a qualifying
24 APM participant (as those terms are defined in sec-
25 tion 1833(z) of the Social Security Act, as added by

1 paragraph (1)) from furnishing a telehealth service
2 for which payment is not made under section
3 1834(m) of the Social Security Act (42 U.S.C.
4 1395m(m)).

5 (6) INTEGRATING MEDICARE ADVANTAGE AL-
6 TERNATIVE PAYMENT MODELS.—Not later than July
7 1, 2015, the Secretary of Health and Human Serv-
8 ices shall submit to Congress a study that examines
9 the feasibility of integrating alternative payment
10 models in the Medicare Advantage payment system.
11 The study shall include the feasibility of including a
12 value-based modifier and whether such modifier
13 should be budget neutral.

14 (7) STUDY AND REPORT ON FRAUD RELATED
15 TO ALTERNATIVE PAYMENT MODELS UNDER THE
16 MEDICARE PROGRAM.—

17 (A) STUDY.—The Secretary of Health and
18 Human Services, in consultation with the In-
19 spector General of the Department of Health
20 and Human Services, shall conduct a study
21 that—

22 (i) examines the applicability of the
23 Federal fraud prevention laws to items and
24 services furnished under title XVIII of the
25 Social Security Act for which payment is

1 made under an alternative payment model
2 (as defined in section 1833(z)(3)(C) of
3 such Act (42 U.S.C. 1395l(z)(3)(C)));

4 (ii) identifies aspects of such alter-
5 native payment models that are vulnerable
6 to fraudulent activity; and

7 (iii) examines the implications of waiv-
8 ers to such laws granted in support of such
9 alternative payment models, including
10 under any potential expansion of such
11 models.

12 (B) REPORT.—Not later than 2 years after
13 the date of the enactment of this Act, the Sec-
14 retary shall submit to Congress a report con-
15 taining the results of the study conducted under
16 subparagraph (A). Such report shall include
17 recommendations for actions to be taken to re-
18 duce the vulnerability of such alternative pay-
19 ment models to fraudulent activity. Such report
20 also shall include, as appropriate, recommenda-
21 tions of the Inspector General for changes in
22 Federal fraud prevention laws to reduce such
23 vulnerability.

24 (f) IMPROVING PAYMENT ACCURACY.—

1 (1) STUDIES AND REPORTS OF EFFECT OF CER-
2 TAIN INFORMATION ON QUALITY AND RESOURCE
3 USE.—

4 (A) STUDY USING EXISTING MEDICARE
5 DATA.—

6 (i) STUDY.—The Secretary of Health
7 and Human Services (in this subsection re-
8 ferred to as the “Secretary”) shall conduct
9 a study that examines the effect of individ-
10 uals’ socioeconomic status on quality and
11 resource use outcome measures for individ-
12 uals under the Medicare program (such as
13 to recognize that less healthy individuals
14 may require more intensive interventions).
15 The study shall use information collected
16 on such individuals in carrying out such
17 program, such as urban and rural location,
18 eligibility for Medicaid (recognizing and ac-
19 counting for varying Medicaid eligibility
20 across States), and eligibility for benefits
21 under the supplemental security income
22 (SSI) program. The Secretary shall carry
23 out this paragraph acting through the As-
24 sistant Secretary for Planning and Evalua-
25 tion.

1 (ii) REPORT.—Not later than 2 years
2 after the date of the enactment of this Act,
3 the Secretary shall submit to Congress a
4 report on the study conducted under clause
5 (i).

6 (B) STUDY USING OTHER DATA.—

7 (i) STUDY.—The Secretary shall con-
8 duct a study that examines the impact of
9 risk factors, such as those described in sec-
10 tion 1848(p)(3) of the Social Security Act
11 (42 U.S.C. 1395w-4(p)(3)), race, health
12 literacy, limited English proficiency (LEP),
13 and patient activation, on quality and re-
14 source use outcome measures under the
15 Medicare program (such as to recognize
16 that less healthy individuals may require
17 more intensive interventions). In con-
18 ducting such study the Secretary may use
19 existing Federal data and collect such ad-
20 ditional data as may be necessary to com-
21 plete the study.

22 (ii) REPORT.—Not later than 5 years
23 after the date of the enactment of this Act,
24 the Secretary shall submit to Congress a

1 report on the study conducted under clause
2 (i).

3 (C) EXAMINATION OF DATA IN CON-
4 DUCTING STUDIES.—In conducting the studies
5 under subparagraphs (A) and (B), the Sec-
6 retary shall examine what non-Medicare data
7 sets, such as data from the American Commu-
8 nity Survey (ACS), can be useful in conducting
9 the types of studies under such paragraphs and
10 how such data sets that are identified as useful
11 can be coordinated with Medicare administra-
12 tive data in order to improve the overall data
13 set available to do such studies and for the ad-
14 ministration of the Medicare program.

15 (D) RECOMMENDATIONS TO ACCOUNT FOR
16 INFORMATION IN PAYMENT ADJUSTMENT
17 MECHANISMS.—If the studies conducted under
18 subparagraphs (A) and (B) find a relationship
19 between the factors examined in the studies and
20 quality and resource use outcome measures,
21 then the Secretary shall also provide rec-
22 ommendations for how the Centers for Medicare
23 & Medicaid Services should—

24 (i) obtain access to the necessary data
25 (if such data is not already being collected)

1 on such factors, including recommenda-
2 tions on how to address barriers to the
3 Centers in accessing such data; and

4 (ii) account for such factors in deter-
5 mining payment adjustments based on
6 quality and resource use outcome measures
7 under the eligible professional Merit-based
8 Incentive Payment System under section
9 1848(q) of the Social Security Act (42
10 U.S.C. 1395w-4(q)) and, as the Secretary
11 determines appropriate, other similar pro-
12 visions of title XVIII of such Act.

13 (E) FUNDING.—There are hereby appro-
14 priated from the Federal Supplementary Med-
15 ical Insurance Trust Fund under section 1841
16 of the Social Security Act to the Secretary to
17 carry out this paragraph \$6,000,000, to remain
18 available until expended.

19 (2) CMS ACTIVITIES.—

20 (A) HIERARCHAL CONDITION CATEGORY
21 (HCC) IMPROVEMENT.—Taking into account the
22 relevant studies conducted and recommenda-
23 tions made in reports under paragraph (1), the
24 Secretary, on an ongoing basis, shall, as the
25 Secretary determines appropriate, estimate how

1 an individual's health status and other risk fac-
2 tors affect quality and resource use outcome
3 measures and, as feasible, shall incorporate in-
4 formation from quality and resource use out-
5 come measurement (including care episode and
6 patient condition groups) into provisions of title
7 XVIII of the Social Security Act that are simi-
8 lar to the eligible professional Merit-based In-
9 centive Payment System under section 1848(q)
10 of such Act.

11 (B) ACCOUNTING FOR OTHER FACTORS IN
12 PAYMENT ADJUSTMENT MECHANISMS.—

13 (i) IN GENERAL.—Taking into ac-
14 count the studies conducted and rec-
15 ommendations made in reports under para-
16 graph (1) and other information as appro-
17 priate, the Secretary shall, as the Sec-
18 retary determines appropriate, account for
19 identified factors with an effect on quality
20 and resource use outcome measures when
21 determining payment adjustment mecha-
22 nisms under provisions of title XVIII of
23 the Social Security Act that are similar to
24 the eligible professional Merit-based Incen-

1 tive Payment System under section
2 1848(q) of such Act.

3 (ii) ACCESSING DATA.—The Secretary
4 shall collect or otherwise obtain access to
5 the data necessary to carry out this para-
6 graph through existing and new data
7 sources.

8 (iii) PERIODIC ANALYSES.—The Sec-
9 retary shall carry out periodic analyses, at
10 least every 3 years, based on the factors
11 referred to in clause (i) so as to monitor
12 changes in possible relationships.

13 (C) FUNDING.—There are hereby appro-
14 priated from the Federal Supplementary Med-
15 ical Insurance Trust Fund under section 1841
16 of the Social Security Act to the Secretary to
17 carry out this paragraph and the application of
18 this paragraph to the Merit-based Incentive
19 Payment System under section 1848(q) of such
20 Act \$10,000,000, to remain available until ex-
21 pended.

22 (3) STRATEGIC PLAN FOR ACCESSING RACE
23 AND ETHNICITY DATA.—Not later than 18 months
24 after the date of the enactment of this Act, the Sec-
25 retary shall develop and report to Congress on a

1 strategic plan for collecting or otherwise accessing
2 data on race and ethnicity for purposes of carrying
3 out the eligible professional Merit-based Incentive
4 Payment System under section 1848(q) of the Social
5 Security Act and, as the Secretary determines ap-
6 propriate, other similar provisions of title XVIII of
7 such Act.

8 (g) COLLABORATING WITH THE PHYSICIAN, PRACTI-
9 TIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
10 IMPROVE RESOURCE USE MEASUREMENT.—Section 1848
11 of the Social Security Act (42 U.S.C. 1395w-4), as
12 amended by subsection (c), is further amended by adding
13 at the end the following new subsection:

14 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-
15 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
16 IMPROVE RESOURCE USE MEASUREMENT.—

17 “(1) IN GENERAL.—In order to involve the phy-
18 sician, practitioner, and other stakeholder commu-
19 nities in enhancing the infrastructure for resource
20 use measurement, including for purposes of the
21 Merit-based Incentive Payment System under sub-
22 section (q) and alternative payment models under
23 section 1833(z), the Secretary shall undertake the
24 steps described in the succeeding provisions of this
25 subsection.

1 “(2) DEVELOPMENT OF CARE EPISODE AND PA-
2 TIENT CONDITION GROUPS AND CLASSIFICATION
3 CODES.—

4 “(A) IN GENERAL.—In order to classify
5 similar patients into care episode groups and
6 patient condition groups, the Secretary shall
7 undertake the steps described in the succeeding
8 provisions of this paragraph.

9 “(B) PUBLIC AVAILABILITY OF EXISTING
10 EFFORTS TO DESIGN AN EPISODE GROUPER.—
11 Not later than 120 days after the date of the
12 enactment of this subsection, the Secretary
13 shall post on the Internet website of the Cen-
14 ters for Medicare & Medicaid Services a list of
15 the episode groups developed pursuant to sub-
16 section (n)(9)(A) and related descriptive infor-
17 mation.

18 “(C) STAKEHOLDER INPUT.—The Sec-
19 retary shall accept, through the date that is 60
20 days after the day the Secretary posts the list
21 pursuant to subparagraph (B), suggestions
22 from physician specialty societies, applicable
23 practitioner organizations, and other stake-
24 holders for episode groups in addition to those
25 posted pursuant to such subparagraph, and

1 specific clinical criteria and patient characteris-
2 tics to classify patients into—

3 “(i) care episode groups; and

4 “(ii) patient condition groups.

5 “(D) DEVELOPMENT OF PROPOSED CLAS-
6 SIFICATION CODES.—

7 “(i) IN GENERAL.—Taking into ac-
8 count the information described in sub-
9 paragraph (B) and the information re-
10 ceived under subparagraph (C), the Sec-
11 retary shall—

12 “(I) establish care episode groups
13 and patient condition groups, which
14 account for a target of an estimated
15 $\frac{2}{3}$ of expenditures under parts A and
16 B; and

17 “(II) assign codes to such
18 groups.

19 “(ii) CARE EPISODE GROUPS.—In es-
20 tablishing the care episode groups under
21 clause (i), the Secretary shall take into ac-
22 count—

23 “(I) the patient’s clinical prob-
24 lems at the time items and services
25 are furnished during an episode of

1 care, such as the clinical conditions or
2 diagnoses, whether or not inpatient
3 hospitalization is anticipated or oc-
4 curs, and the principal procedures or
5 services planned or furnished; and

6 “(II) other factors determined
7 appropriate by the Secretary.

8 “(iii) PATIENT CONDITION GROUPS.—

9 In establishing the patient condition
10 groups under clause (i), the Secretary shall
11 take into account—

12 “(I) the patient’s clinical history
13 at the time of each medical visit, such
14 as the patient’s combination of chron-
15 ic conditions, current health status,
16 and recent significant history (such as
17 hospitalization and major surgery dur-
18 ing a previous period, such as 3
19 months); and

20 “(II) other factors determined
21 appropriate by the Secretary, such as
22 eligibility status under this title (in-
23 cluding eligibility under section
24 226(a), 226(b), or 226A, and dual eli-
25 gibility under this title and title XIX).

1 “(E) DRAFT CARE EPISODE AND PATIENT
2 CONDITION GROUPS AND CLASSIFICATION
3 CODES.—Not later than 180 days after the end
4 of the comment period described in subpara-
5 graph (C), the Secretary shall post on the
6 Internet website of the Centers for Medicare &
7 Medicaid Services a draft list of the care epi-
8 sode and patient condition codes established
9 under subparagraph (D) (and the criteria and
10 characteristics assigned to such code).

11 “(F) SOLICITATION OF INPUT.—The Sec-
12 retary shall seek, through the date that is 60
13 days after the Secretary posts the list pursuant
14 to subparagraph (E), comments from physician
15 specialty societies, applicable practitioner orga-
16 nizations, and other stakeholders, including rep-
17 resentatives of individuals entitled to benefits
18 under part A or enrolled under this part, re-
19 garding the care episode and patient condition
20 groups (and codes) posted under subparagraph
21 (E). In seeking such comments, the Secretary
22 shall use one or more mechanisms (other than
23 notice and comment rulemaking) that may in-
24 clude use of open door forums, town hall meet-
25 ings, or other appropriate mechanisms.

1 “(G) OPERATIONAL LIST OF CARE EPI-
2 SODE AND PATIENT CONDITION GROUPS AND
3 CODES.—Not later than 180 days after the end
4 of the comment period described in subpara-
5 graph (F), taking into account the comments
6 received under such subparagraph, the Sec-
7 retary shall post on the Internet website of the
8 Centers for Medicare & Medicaid Services an
9 operational list of care episode and patient con-
10 dition codes (and the criteria and characteris-
11 tics assigned to such code).

12 “(H) SUBSEQUENT REVISIONS.—Not later
13 than November 1 of each year (beginning with
14 2017), the Secretary shall, through rulemaking,
15 make revisions to the operational lists of care
16 episode and patient condition codes as the Sec-
17 retary determines may be appropriate. Such re-
18 visions may be based on experience, new infor-
19 mation developed pursuant to subsection
20 (n)(9)(A), and input from the physician spe-
21 cialty societies, applicable practitioner organiza-
22 tions, and other stakeholders, including rep-
23 resentatives of individuals entitled to benefits
24 under part A or enrolled under this part.

1 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-
2 CIANS OR PRACTITIONERS.—

3 “(A) IN GENERAL.—In order to facilitate
4 the attribution of patients and episodes (in
5 whole or in part) to one or more physicians or
6 applicable practitioners furnishing items and
7 services, the Secretary shall undertake the steps
8 described in the succeeding provisions of this
9 paragraph.

10 “(B) DEVELOPMENT OF PATIENT RELA-
11 TIONSHIP CATEGORIES AND CODES.—The Sec-
12 retary shall develop patient relationship cat-
13 egories and codes that define and distinguish
14 the relationship and responsibility of a physi-
15 cian or applicable practitioner with a patient at
16 the time of furnishing an item or service. Such
17 patient relationship categories shall include dif-
18 ferent relationships of the physician or applica-
19 ble practitioner to the patient (and the codes
20 may reflect combinations of such categories),
21 such as a physician or applicable practitioner
22 who—

23 “(i) considers himself to have the
24 primary responsibility for the general and

1 ongoing care for the patient over extended
2 periods of time;

3 “(ii) considers themselves to be the lead
4 physician or practitioner and who furnishes
5 items and services and coordinates care
6 furnished by other physicians or practi-
7 tioners for the patient during an acute epi-
8 sode;

9 “(iii) furnishes items and services to
10 the patient on a continuing basis during an
11 acute episode of care, but in a supportive
12 rather than a lead role;

13 “(iv) furnishes items and services to
14 the patient on an occasional basis, usually
15 at the request of another physician or
16 practitioner; or

17 “(v) furnishes items and services only
18 as ordered by another physician or practi-
19 tioner.

20 “(C) DRAFT LIST OF PATIENT RELATION-
21 SHIP CATEGORIES AND CODES.—Not later than
22 270 days after the date of the enactment of this
23 subsection, the Secretary shall post on the
24 Internet website of the Centers for Medicare &
25 Medicaid Services a draft list of the patient re-

1 relationship categories and codes developed under
2 subparagraph (B).

3 “(D) STAKEHOLDER INPUT.—The Sec-
4 retary shall seek, through the date that is 60
5 days after the Secretary posts the list pursuant
6 to subparagraph (C), comments from physician
7 specialty societies, applicable practitioner orga-
8 nizations, and other stakeholders, including rep-
9 resentatives of individuals entitled to benefits
10 under part A or enrolled under this part, re-
11 garding the patient relationship categories and
12 codes posted under subparagraph (C). In seek-
13 ing such comments, the Secretary shall use one
14 or more mechanisms (other than notice and
15 comment rulemaking) that may include open
16 door forums, town hall meetings, or other ap-
17 propriate mechanisms.

18 “(E) OPERATIONAL LIST OF PATIENT RE-
19 LATIONSHIP CATEGORIES AND CODES.—Not
20 later than 180 days after the end of the com-
21 ment period described in subparagraph (D),
22 taking into account the comments received
23 under such subparagraph, the Secretary shall
24 post on the Internet website of the Centers for

1 Medicare & Medicaid Services an operational
2 list of patient relationship categories and codes.

3 “(F) SUBSEQUENT REVISIONS.—Not later
4 than November 1 of each year (beginning with
5 2017), the Secretary shall, through rulemaking,
6 make revisions to the operational list of patient
7 relationship categories and codes as the Sec-
8 retary determines appropriate. Such revisions
9 may be based on experience, new information
10 developed pursuant to subsection (n)(9)(A), and
11 input from the physician specialty societies, ap-
12 plicable practitioner organizations, and other
13 stakeholders, including representatives of indi-
14 viduals entitled to benefits under part A or en-
15 rolled under this part.

16 “(4) REPORTING OF INFORMATION FOR RE-
17 SOURCE USE MEASUREMENT.—Claims submitted for
18 items and services furnished by a physician or appli-
19 cable practitioner on or after January 1, 2017, shall,
20 as determined appropriate by the Secretary, in-
21 clude—

22 “(A) applicable codes established under
23 paragraphs (2) and (3); and

24 “(B) the national provider identifier of the
25 ordering physician or applicable practitioner (if

1 different from the billing physician or applicable
2 practitioner).

3 “(5) METHODOLOGY FOR RESOURCE USE ANAL-
4 YSIS.—

5 “(A) IN GENERAL.—In order to evaluate
6 the resources used to treat patients (with re-
7 spect to care episode and patient condition
8 groups), the Secretary shall—

9 “(i) use the patient relationship codes
10 reported on claims pursuant to paragraph
11 (4) to attribute patients (in whole or in
12 part) to one or more physicians and appli-
13 cable practitioners;

14 “(ii) use the care episode and patient
15 condition codes reported on claims pursu-
16 ant to paragraph (4) as a basis to compare
17 similar patients and care episodes and pa-
18 tient condition groups; and

19 “(iii) conduct an analysis of resource
20 use (with respect to care episodes and pa-
21 tient condition groups of such patients), as
22 the Secretary determines appropriate.

23 “(B) ANALYSIS OF PATIENTS OF PHYSI-
24 CIANS AND PRACTITIONERS.—In conducting the
25 analysis described in subparagraph (A)(iii) with

1 respect to patients attributed to physicians and
2 applicable practitioners, the Secretary shall, as
3 feasible—

4 “(i) use the claims data experience of
5 such patients by patient condition codes
6 during a common period, such as 12
7 months; and

8 “(ii) use the claims data experience of
9 such patients by care episode codes—

10 “(I) in the case of episodes with-
11 out a hospitalization, during periods
12 of time (such as the number of days)
13 determined appropriate by the Sec-
14 retary; and

15 “(II) in the case of episodes with
16 a hospitalization, during periods of
17 time (such as the number of days) be-
18 fore, during, and after the hospitaliza-
19 tion.

20 “(C) MEASUREMENT OF RESOURCE USE.—

21 In measuring such resource use, the Sec-
22 retary—

23 “(i) shall use per patient total allowed
24 charges for all services under part A and
25 this part (and, if the Secretary determines

1 appropriate, part D) for the analysis of pa-
2 tient resource use, by care episode codes
3 and by patient condition codes; and

4 “(ii) may, as determined appropriate,
5 use other measures of allowed charges
6 (such as subtotals for categories of items
7 and services) and measures of utilization of
8 items and services (such as frequency of
9 specific items and services and the ratio of
10 specific items and services among attrib-
11 uted patients or episodes).

12 “(D) STAKEHOLDER INPUT.—The Sec-
13 retary shall seek comments from the physician
14 specialty societies, applicable practitioner orga-
15 nizations, and other stakeholders, including rep-
16 resentatives of individuals entitled to benefits
17 under part A or enrolled under this part, re-
18 garding the resource use methodology estab-
19 lished pursuant to this paragraph. In seeking
20 comments the Secretary shall use one or more
21 mechanisms (other than notice and comment
22 rulemaking) that may include open door fo-
23 rums, town hall meetings, or other appropriate
24 mechanisms.

1 “(6) IMPLEMENTATION.—To the extent that
2 the Secretary contracts with an entity to carry out
3 any part of the provisions of this subsection, the
4 Secretary may not contract with an entity or an en-
5 tity with a subcontract if the entity or subcon-
6 tracting entity currently makes recommendations to
7 the Secretary on relative values for services under
8 the fee schedule for physicians’ services under this
9 section.

10 “(7) LIMITATION.—There shall be no adminis-
11 trative or judicial review under section 1869, section
12 1878, or otherwise of—

13 “(A) care episode and patient condition
14 groups and codes established under paragraph
15 (2);

16 “(B) patient relationship categories and
17 codes established under paragraph (3); and

18 “(C) measurement of, and analyses of re-
19 source use with respect to, care episode and pa-
20 tient condition codes and patient relationship
21 codes pursuant to paragraph (5).

22 “(8) ADMINISTRATION.—Chapter 35 of title 44,
23 United States Code, shall not apply to this section.

24 “(9) DEFINITIONS.—In this section:

1 “(A) PHYSICIAN.—The term ‘physician’
2 has the meaning given such term in section
3 1861(r)(1).

4 “(B) APPLICABLE PRACTITIONER.—The
5 term ‘applicable practitioner’ means—

6 “(i) a physician assistant, nurse prac-
7 titioner, and clinical nurse specialist (as
8 such terms are defined in section
9 1861(aa)(5)), and a certified registered
10 nurse anesthetist (as defined in section
11 1861(bb)(2)); and

12 “(ii) beginning January 1, 2018, such
13 other eligible professionals (as defined in
14 subsection (k)(3)(B)) as specified by the
15 Secretary.

16 “(10) CLARIFICATION.—The provisions of sec-
17 tions 1890(b)(7) and 1890A shall not apply to this
18 subsection.”.

19 **SEC. 102. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**
20 **OPMENT.**

21 Section 1848 of the Social Security Act (42 U.S.C.
22 1395w-4), as amended by subsections (c) and (g) of sec-
23 tion 101, is further amended by inserting at the end the
24 following new subsection:

1 “(s) PRIORITIES AND FUNDING FOR MEASURE DE-
2 VELOPMENT.—

3 “(1) PLAN IDENTIFYING MEASURE DEVELOP-
4 MENT PRIORITIES AND TIMELINES.—

5 “(A) DRAFT MEASURE DEVELOPMENT
6 PLAN.—Not later than January 1, 2015, the
7 Secretary shall develop, and post on the Inter-
8 net website of the Centers for Medicare & Med-
9 icaid Services, a draft plan for the development
10 of quality measures for application under the
11 applicable provisions (as defined in paragraph
12 (5)). Under such plan the Secretary shall—

13 “(i) address how measures used by
14 private payers and integrated delivery sys-
15 tems could be incorporated under title
16 XVIII;

17 “(ii) describe how coordination, to the
18 extent possible, will occur across organiza-
19 tions developing such measures; and

20 “(iii) take into account how clinical
21 best practices and clinical practice guide-
22 lines should be used in the development of
23 quality measures.

1 “(B) QUALITY DOMAINS.—For purposes of
2 this subsection, the term ‘quality domains’
3 means at least the following domains:

4 “(i) Clinical care.

5 “(ii) Safety.

6 “(iii) Care coordination.

7 “(iv) Patient and caregiver experience.

8 “(v) Population health and preven-
9 tion.

10 “(C) CONSIDERATION.—In developing the
11 draft plan under this paragraph, the Secretary
12 shall consider—

13 “(i) gap analyses conducted by the en-
14 tity with a contract under section 1890(a)
15 or other contractors or entities;

16 “(ii) whether measures are applicable
17 across health care settings;

18 “(iii) clinical practice improvement ac-
19 tivities submitted under subsection
20 (q)(2)(C)(iv) for identifying possible areas
21 for future measure development and identi-
22 fying existing gaps with respect to such
23 measures; and

24 “(iv) the quality domains applied
25 under this subsection.

1 “(D) PRIORITIES.—In developing the draft
2 plan under this paragraph, the Secretary shall
3 give priority to the following types of measures:

4 “(i) Outcome measures, including pa-
5 tient reported outcome and functional sta-
6 tus measures.

7 “(ii) Patient experience measures.

8 “(iii) Care coordination measures.

9 “(iv) Measures of appropriate use of
10 services, including measures of over use.

11 “(E) STAKEHOLDER INPUT.—The Sec-
12 retary shall accept through March 1, 2015,
13 comments on the draft plan posted under para-
14 graph (1)(A) from the public, including health
15 care providers, payers, consumers, and other
16 stakeholders.

17 “(F) FINAL MEASURE DEVELOPMENT
18 PLAN.—Not later than May 1, 2015, taking
19 into account the comments received under this
20 subparagraph, the Secretary shall finalize the
21 plan and post on the Internet website of the
22 Centers for Medicare & Medicaid Services an
23 operational plan for the development of quality
24 measures for use under the applicable provi-

1 sions. Such plan shall be updated as appro-
2 priate.

3 “(2) CONTRACTS AND OTHER ARRANGEMENTS
4 FOR QUALITY MEASURE DEVELOPMENT.—

5 “(A) IN GENERAL.—The Secretary shall
6 enter into contracts or other arrangements with
7 entities for the purpose of developing, improv-
8 ing, updating, or expanding in accordance with
9 the plan under paragraph (1) quality measures
10 for application under the applicable provisions.
11 Such entities shall include organizations with
12 quality measure development expertise.

13 “(B) PRIORITIZATION.—

14 “(i) IN GENERAL.—In entering into
15 contracts or other arrangements under
16 subparagraph (A), the Secretary shall give
17 priority to the development of the types of
18 measures described in paragraph (1)(D).

19 “(ii) CONSIDERATION.—In selecting
20 measures for development under this sub-
21 section, the Secretary shall consider—

22 “(I) whether such measures
23 would be electronically specified; and

1 “(II) clinical practice guidelines
2 to the extent that such guidelines
3 exist.

4 “(3) ANNUAL REPORT BY THE SECRETARY.—

5 “(A) IN GENERAL.—Not later than May 1,
6 2016, and annually thereafter, the Secretary
7 shall post on the Internet website of the Cen-
8 ters for Medicare & Medicaid Services a report
9 on the progress made in developing quality
10 measures for application under the applicable
11 provisions.

12 “(B) REQUIREMENTS.—Each report sub-
13 mitted pursuant to subparagraph (A) shall in-
14 clude the following:

15 “(i) A description of the Secretary’s
16 efforts to implement this paragraph.

17 “(ii) With respect to the measures de-
18 veloped during the previous year—

19 “(I) a description of the total
20 number of quality measures developed
21 and the types of such measures, such
22 as an outcome or patient experience
23 measure;

24 “(II) the name of each measure
25 developed;

1 “(III) the name of the developer
2 and steward of each measure;

3 “(IV) with respect to each type
4 of measure, an estimate of the total
5 amount expended under this title to
6 develop all measures of such type; and

7 “(V) whether the measure would
8 be electronically specified.

9 “(iii) With respect to measures in de-
10 velopment at the time of the report—

11 “(I) the information described in
12 clause (ii), if available; and

13 “(II) a timeline for completion of
14 the development of such measures.

15 “(iv) A description of any updates to
16 the plan under paragraph (1) (including
17 newly identified gaps and the status of pre-
18 viously identified gaps) and the inventory
19 of measures applicable under the applicable
20 provisions.

21 “(v) Other information the Secretary
22 determines to be appropriate.

23 “(4) STAKEHOLDER INPUT.—With respect to
24 paragraph (1), the Secretary shall seek stakeholder
25 input with respect to—

1 “(A) the identification of gaps where no
2 quality measures exist, particularly with respect
3 to the types of measures described in paragraph
4 (1)(D);

5 “(B) prioritizing quality measure develop-
6 ment to address such gaps; and

7 “(C) other areas related to quality measure
8 development determined appropriate by the Sec-
9 retary.

10 “(5) DEFINITION OF APPLICABLE PROVI-
11 SIONS.—In this subsection, the term ‘applicable pro-
12 visions’ means the following provisions:

13 “(A) Subsection (q)(2)(B)(i).

14 “(B) Section 1833(z)(2)(C).

15 “(6) FUNDING.—For purposes of carrying out
16 this subsection, the Secretary shall provide for the
17 transfer, from the Federal Supplementary Medical
18 Insurance Trust Fund under section 1841, of
19 \$15,000,000 to the Centers for Medicare & Medicaid
20 Services Program Management Account for each of
21 fiscal years 2014 through 2018. Amounts trans-
22 ferred under this paragraph shall remain available
23 through the end of fiscal year 2021.”.

1 **SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDI-**
 2 **VIDUALS WITH CHRONIC CARE NEEDS.**

3 (a) IN GENERAL.—Section 1848(b) of the Social Se-
 4 curity Act (42 U.S.C. 1395w-4(b)) is amended by adding
 5 at the end the following new paragraph:

6 “(8) ENCOURAGING CARE MANAGEMENT FOR
 7 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

8 “(A) IN GENERAL.—In order to encourage
 9 the management of care by an applicable pro-
 10 vider (as defined in subparagraph (B)) for indi-
 11 viduals with chronic care needs the Secretary
 12 shall—

13 “(i) establish one or more HCPCS
 14 codes for chronic care management serv-
 15 ices for such individuals; and

16 “(ii) subject to subparagraph (D),
 17 make payment (as the Secretary deter-
 18 mines to be appropriate) under this section
 19 for such management services furnished on
 20 or after January 1, 2015, by an applicable
 21 provider.

22 “(B) APPLICABLE PROVIDER DEFINED.—
 23 For purposes of this paragraph, the term ‘ap-
 24 plicable provider’ means a physician (as defined
 25 in section 1861(r)(1)), physician assistant or
 26 nurse practitioner (as defined in section

1 1861(aa)(5)(A)), or clinical nurse specialist (as
2 defined in section 1861(aa)(5)(B)) who fur-
3 nishes services as part of a patient-centered
4 medical home or a comparable specialty practice
5 that—

6 “(i) is recognized as such a medical
7 home or comparable specialty practice by
8 an organization that is recognized by the
9 Secretary for purposes of such recognition
10 as such a medical home or practice; or

11 “(ii) meets such other comparable
12 qualifications as the Secretary determines
13 to be appropriate.

14 “(C) BUDGET NEUTRALITY.—The budget
15 neutrality provision under subsection
16 (c)(2)(B)(ii)(II) shall apply in establishing the
17 payment under subparagraph (A)(ii).

18 “(D) POLICIES RELATING TO PAYMENT.—
19 In carrying out this paragraph, with respect to
20 chronic care management services, the Sec-
21 retary shall—

22 “(i) make payment to only one appli-
23 cable provider for such services furnished
24 to an individual during a period;

1 “(ii) not make payment under sub-
2 paragraph (A) if such payment would be
3 duplicative of payment that is otherwise
4 made under this title for such services
5 (such as in the case of hospice care or
6 home health services); and

7 “(iii) not require that an annual
8 wellness visit (as defined in section
9 1861(hhh)) or an initial preventive phys-
10 ical examination (as defined in section
11 1861(ww)) be furnished as a condition of
12 payment for such management services.”.

13 (b) EDUCATION AND OUTREACH.—

14 (1) CAMPAIGN.—

15 (A) IN GENERAL.—The Secretary of
16 Health and Human Services (in this subsection
17 referred to as the “Secretary”) shall conduct an
18 education and outreach campaign to inform
19 professionals who furnish items and services
20 under part B of title XVIII of the Social Secu-
21 rity Act and individuals enrolled under such
22 part of the benefits of chronic care management
23 services described in section 1848(b)(8) of the
24 Social Security Act, as added by subsection (a),

1 and encourage such individuals with chronic
2 care needs to receive such services.

3 (B) REQUIREMENTS.—Such campaign
4 shall—

5 (i) be directed by the Office of Rural
6 Health Policy of the Department of Health
7 and Human Services and the Office of Mi-
8 nority Health of the Centers for Medicare
9 & Medicaid Services; and

10 (ii) focus on encouraging participation
11 by underserved rural populations and ra-
12 cial and ethnic minority populations.

13 (2) REPORT.—

14 (A) IN GENERAL.—Not later than Decem-
15 ber 31, 2017, the Secretary shall submit to
16 Congress a report on the use of chronic care
17 management services described in such section
18 1848(b)(8) by individuals living in rural areas
19 and by racial and ethnic minority populations.
20 Such report shall—

21 (i) identify barriers to receiving chron-
22 ic care management services; and

23 (ii) make recommendations for in-
24 creasing the appropriate use of chronic
25 care management services.

1 **SEC. 104. ENSURING ACCURATE VALUATION OF SERVICES**
2 **UNDER THE PHYSICIAN FEE SCHEDULE.**

3 (a) **AUTHORITY TO COLLECT AND USE INFORMA-**
4 **TION ON PHYSICIANS' SERVICES IN THE DETERMINATION**
5 **OF RELATIVE VALUES.—**

6 (1) **IN GENERAL.—**Section 1848(c)(2) of the
7 Social Security Act (42 U.S.C. 1395w-4(c)(2)) is
8 amended by adding at the end the following new
9 subparagraph:

10 “(M) **AUTHORITY TO COLLECT AND USE**
11 **INFORMATION ON PHYSICIANS' SERVICES IN**
12 **THE DETERMINATION OF RELATIVE VALUES.—**

13 “(i) **COLLECTION OF INFORMATION.—**
14 Notwithstanding any other provision of
15 law, the Secretary may collect or obtain in-
16 formation on the resources directly or indi-
17 rectly related to furnishing services for
18 which payment is made under the fee
19 schedule established under subsection (b).
20 Such information may be collected or ob-
21 tained from any eligible professional or any
22 other source.

23 “(ii) **USE OF INFORMATION.—**Not-
24 withstanding any other provision of law,
25 subject to clause (v), the Secretary may
26 (as the Secretary determines appropriate)

1 use information collected or obtained pur-
2 suant to clause (i) in the determination of
3 relative values for services under this sec-
4 tion.

5 “(iii) TYPES OF INFORMATION.—The
6 types of information described in clauses
7 (i) and (ii) may, at the Secretary’s discre-
8 tion, include any or all of the following:

9 “(I) Time involved in furnishing
10 services.

11 “(II) Amounts and types of prac-
12 tice expense inputs involved with fur-
13 nishing services.

14 “(III) Prices (net of any dis-
15 counts) for practice expense inputs,
16 which may include paid invoice prices
17 or other documentation or records.

18 “(IV) Overhead and accounting
19 information for practices of physicians
20 and other suppliers.

21 “(V) Any other element that
22 would improve the valuation of serv-
23 ices under this section.

24 “(iv) INFORMATION COLLECTION
25 MECHANISMS.—Information may be col-

1 lected or obtained pursuant to this sub-
2 paragraph from any or all of the following:

3 “(I) Surveys of physicians, other
4 suppliers, providers of services, manu-
5 facturers, and vendors.

6 “(II) Surgical logs, billing sys-
7 tems, or other practice or facility
8 records.

9 “(III) Electronic health records.

10 “(IV) Any other mechanism de-
11 termined appropriate by the Sec-
12 retary.

13 “(v) TRANSPARENCY OF USE OF IN-
14 FORMATION.—

15 “(I) IN GENERAL.—Subject to
16 subclauses (II) and (III), if the Sec-
17 retary uses information collected or
18 obtained under this subparagraph in
19 the determination of relative values
20 under this subsection, the Secretary
21 shall disclose the information source
22 and discuss the use of such informa-
23 tion in such determination of relative
24 values through notice and comment
25 rulemaking.

1 “(II) THRESHOLDS FOR USE.—

2 The Secretary may establish thresh-
3 olds in order to use such information,
4 including the exclusion of information
5 collected or obtained from eligible pro-
6 fessionals who use very high resources
7 (as determined by the Secretary) in
8 furnishing a service.

9 “(III) DISCLOSURE OF INFORMA-
10 TION.—The Secretary shall make ag-

11 gregate information available under
12 this subparagraph but shall not dis-
13 close information in a form or manner
14 that identifies an eligible professional
15 or a group practice, or information
16 collected or obtained pursuant to a
17 nondisclosure agreement.

18 “(vi) INCENTIVE TO PARTICIPATE.—

19 The Secretary may provide for such pay-
20 ments under this part to an eligible profes-
21 sional that submits such solicited informa-
22 tion under this subparagraph as the Sec-
23 retary determines appropriate in order to
24 compensate such eligible professional for
25 such submission. Such payments shall be

1 provided in a form and manner specified
2 by the Secretary.

3 “(vii) ADMINISTRATION.—Chapter 35
4 of title 44, United States Code, shall not
5 apply to information collected or obtained
6 under this subparagraph.

7 “(viii) DEFINITION OF ELIGIBLE PRO-
8 FESSIONAL.—In this subparagraph, the
9 term ‘eligible professional’ has the meaning
10 given such term in subsection (k)(3)(B).

11 “(ix) FUNDING.—For purposes of car-
12 rying out this subparagraph, in addition to
13 funds otherwise appropriated, the Sec-
14 retary shall provide for the transfer, from
15 the Federal Supplementary Medical Insur-
16 ance Trust Fund under section 1841, of
17 \$2,000,000 to the Centers for Medicare &
18 Medicaid Services Program Management
19 Account for each fiscal year beginning with
20 fiscal year 2014. Amounts transferred
21 under the preceding sentence for a fiscal
22 year shall be available until expended.”.

23 (2) LIMITATION ON REVIEW.—Section
24 1848(i)(1) of the Social Security Act (42 U.S.C.
25 1395w-4(i)(1)) is amended—

1 (A) in subparagraph (D), by striking
2 “and” at the end;

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

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

7 “(F) the collection and use of information
8 in the determination of relative values under
9 subsection (c)(2)(M).”.

10 (b) AUTHORITY FOR ALTERNATIVE APPROACHES TO
11 ESTABLISHING PRACTICE EXPENSE RELATIVE VAL-
12 UES.—Section 1848(c)(2) of the Social Security Act (42
13 U.S.C. 1395w-4(c)(2)), as amended by subsection (a), is
14 amended by adding at the end the following new subpara-
15 graph:

16 “(N) AUTHORITY FOR ALTERNATIVE AP-
17 PROACHES TO ESTABLISHING PRACTICE EX-
18 PENSE RELATIVE VALUES.—The Secretary may
19 establish or adjust practice expense relative val-
20 ues under this subsection using cost, charge, or
21 other data from suppliers or providers of serv-
22 ices, including information collected or obtained
23 under subparagraph (M).”.

24 (c) REVISED AND EXPANDED IDENTIFICATION OF
25 POTENTIALLY MISVALUED CODES.—Section

1 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.
2 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

3 “(ii) IDENTIFICATION OF POTEN-
4 TIALY MISVALUED CODES.—For purposes
5 of identifying potentially misvalued codes
6 pursuant to clause (i)(I), the Secretary
7 shall examine codes (and families of codes
8 as appropriate) based on any or all of the
9 following criteria:

10 “(I) Codes that have experienced
11 the fastest growth.

12 “(II) Codes that have experi-
13 enced substantial changes in practice
14 expenses.

15 “(III) Codes that describe new
16 technologies or services within an ap-
17 propriate time period (such as 3
18 years) after the relative values are ini-
19 tially established for such codes.

20 “(IV) Codes which are multiple
21 codes that are frequently billed in con-
22 junction with furnishing a single serv-
23 ice.

24 “(V) Codes with low relative val-
25 ues, particularly those that are often

1 billed multiple times for a single treat-
2 ment.

3 “(VI) Codes that have not been
4 subject to review since implementation
5 of the fee schedule.

6 “(VII) Codes that account for
7 the majority of spending under the
8 physician fee schedule.

9 “(VIII) Codes for services that
10 have experienced a substantial change
11 in the hospital length of stay or proce-
12 dure time.

13 “(IX) Codes for which there may
14 be a change in the typical site of serv-
15 ice since the code was last valued.

16 “(X) Codes for which there is a
17 significant difference in payment for
18 the same service between different
19 sites of service.

20 “(XI) Codes for which there may
21 be anomalies in relative values within
22 a family of codes.

23 “(XII) Codes for services where
24 there may be efficiencies when a serv-

1 ice is furnished at the same time as
2 other services.

3 “(XIII) Codes with high intra-
4 service work per unit of time.

5 “(XIV) Codes with high practice
6 expense relative value units.

7 “(XV) Codes with high cost sup-
8 plies.

9 “(XVI) Codes as determined ap-
10 propriate by the Secretary.”

11 (d) TARGET FOR RELATIVE VALUE ADJUSTMENTS
12 FOR MISVALUED SERVICES.—

13 (1) IN GENERAL.—Section 1848(c)(2) of the
14 Social Security Act (42 U.S.C. 1395w-4(c)(2)), as
15 amended by subsections (a) and (b), is amended by
16 adding at the end the following new subparagraph:

17 “(O) TARGET FOR RELATIVE VALUE AD-
18 JUSTMENTS FOR MISVALUED SERVICES.—With
19 respect to fee schedules established for each of
20 2015 through 2018, the following shall apply:

21 “(i) DETERMINATION OF NET REDUC-
22 TION IN EXPENDITURES.—For each year,
23 the Secretary shall determine the esti-
24 mated net reduction in expenditures under
25 the fee schedule under this section with re-

1 spect to the year as a result of adjust-
2 ments to the relative values established
3 under this paragraph for misvalued codes.

4 “(ii) BUDGET NEUTRAL REDISTRIBU-
5 TION OF FUNDS IF TARGET MET AND
6 COUNTING OVERAGES TOWARDS THE TAR-
7 GET FOR THE SUCCEEDING YEAR.—If the
8 estimated net reduction in expenditures de-
9 termined under clause (i) for the year is
10 equal to or greater than the target for the
11 year—

12 “(I) reduced expenditures attrib-
13 utable to such adjustments shall be
14 redistributed for the year in a budget
15 neutral manner in accordance with
16 subparagraph (B)(ii)(II); and

17 “(II) the amount by which such
18 reduced expenditures exceeds the tar-
19 get for the year shall be treated as a
20 reduction in expenditures described in
21 clause (i) for the succeeding year, for
22 purposes of determining whether the
23 target has or has not been met under
24 this subparagraph with respect to that
25 year.

1 “(iii) EXEMPTION FROM BUDGET
2 NEUTRALITY IF TARGET NOT MET.—If the
3 estimated net reduction in expenditures de-
4 termined under clause (i) for the year is
5 less than the target for the year, reduced
6 expenditures in an amount equal to the
7 target recapture amount shall not be taken
8 into account in applying subparagraph
9 (B)(ii)(II) with respect to fee schedules be-
10 ginning with 2015.

11 “(iv) TARGET RECAPTURE AMOUNT.—
12 For purposes of clause (iii), the target re-
13 capture amount is, with respect to a year,
14 an amount equal to the difference be-
15 tween—

16 “(I) the target for the year; and
17 “(II) the estimated net reduction
18 in expenditures determined under
19 clause (i) for the year.

20 “(v) TARGET.—For purposes of this
21 subparagraph, with respect to a year, the
22 target is calculated as 0.5 percent of the
23 estimated amount of expenditures under
24 the fee schedule under this section for the
25 year.”.

1 (2) CONFORMING AMENDMENT.—Section
 2 1848(c)(2)(B)(v) of the Social Security Act (42
 3 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by adding
 4 at the end the following new subclause:

5 “(VIII) REDUCTIONS FOR
 6 MISVALUED SERVICES IF TARGET NOT
 7 MET.—Effective for fee schedules be-
 8 ginning with 2015, reduced expendi-
 9 tures attributable to the application of
 10 the target recapture amount described
 11 in subparagraph (O)(iii).”.

12 (e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE
 13 UNIT (RVU) REDUCTIONS.—

14 (1) IN GENERAL.—Section 1848(c) of the So-
 15 cial Security Act (42 U.S.C. 1395w-4(c)) is amend-
 16 ed by adding at the end the following new para-
 17 graph:

18 “(7) PHASE-IN OF SIGNIFICANT RELATIVE
 19 VALUE UNIT (RVU) REDUCTIONS.—Effective for fee
 20 schedules established beginning with 2015, if the
 21 total relative value units for a service for a year
 22 would otherwise be decreased by an estimated
 23 amount equal to or greater than 20 percent as com-
 24 pared to the total relative value units for the pre-
 25 vious year, the applicable adjustments in work, prac-

1 tice expense, and malpractice relative value units
2 shall be phased-in over a 2-year period.”.

3 (2) CONFORMING AMENDMENTS.—Section
4 1848(c)(2) of the Social Security Act (42 U.S.C.
5 1395w-4(c)(2)) is amended—

6 (A) in subparagraph (B)(ii)(I), by striking
7 “subclause (II)” and inserting “subclause (II)
8 and paragraph (7)”; and

9 (B) in subparagraph (K)(iii)(VI)—

10 (i) by striking “provisions of subpara-
11 graph (B)(ii)(II)” and inserting “provi-
12 sions of subparagraph (B)(ii)(II) and para-
13 graph (7)”; and

14 (ii) by striking “under subparagraph
15 (B)(ii)(II)” and inserting “under subpara-
16 graph (B)(ii)(I)”.

17 (f) AUTHORITY TO SMOOTH RELATIVE VALUES
18 WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of
19 the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)) is
20 amended—

21 (1) in each of clauses (i) and (iii), by striking
22 “the service” and inserting “the service or group of
23 services” each place it appears; and

24 (2) in the first sentence of clause (ii), by insert-
25 ing “or group of services” before the period.

1 (g) GAO STUDY AND REPORT ON RELATIVE VALUE
2 SCALE UPDATE COMMITTEE.—

3 (1) STUDY.—The Comptroller General of the
4 United States (in this subsection referred to as the
5 “Comptroller General”) shall conduct a study of the
6 processes used by the Relative Value Scale Update
7 Committee (RUC) to provide recommendations to
8 the Secretary of Health and Human Services regard-
9 ing relative values for specific services under the
10 Medicare physician fee schedule under section 1848
11 of the Social Security Act (42 U.S.C. 1395w–4).

12 (2) REPORT.—Not later than 1 year after the
13 date of the enactment of this Act, the Comptroller
14 General shall submit to Congress a report containing
15 the results of the study conducted under paragraph
16 (1).

17 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-
18 ITIES.—

19 (1) IN GENERAL.—Section 1848(e) of the So-
20 cial Security Act (42 U.S.C. 1395w–4(e)) is amend-
21 ed by adding at the end the following new para-
22 graph:

23 “(6) USE OF MSAS AS FEE SCHEDULE AREAS IN
24 CALIFORNIA.—

1 “(A) IN GENERAL.—Subject to the suc-
2 ceeding provisions of this paragraph and not-
3 withstanding the previous provisions of this
4 subsection, for services furnished on or after
5 January 1, 2017, the fee schedule areas used
6 for payment under this section applicable to
7 California shall be the following:

8 “(i) Each Metropolitan Statistical
9 Area (each in this paragraph referred to as
10 an ‘MSA’), as defined by the Director of
11 the Office of Management and Budget as
12 of December 31 of the previous year, shall
13 be a fee schedule area.

14 “(ii) All areas not included in an MSA
15 shall be treated as a single rest-of-State
16 fee schedule area.

17 “(B) TRANSITION FOR MSAS PREVIOUSLY
18 IN REST-OF-STATE PAYMENT LOCALITY OR IN
19 LOCALITY 3.—

20 “(i) IN GENERAL.—For services fur-
21 nished in California during a year begin-
22 ning with 2017 and ending with 2021 in
23 an MSA in a transition area (as defined in
24 subparagraph (D)), subject to subpara-
25 graph (C), the geographic index values to

1 be applied under this subsection for such
2 year shall be equal to the sum of the fol-
3 lowing:

4 “(I) CURRENT LAW COMPO-
5 NENT.—The old weighting factor (de-
6 scribed in clause (ii)) for such year
7 multiplied by the geographic index
8 values under this subsection for the
9 fee schedule area that included such
10 MSA that would have applied in such
11 area (as estimated by the Secretary)
12 if this paragraph did not apply.

13 “(II) MSA-BASED COMPO-
14 NENT.—The MSA-based weighting
15 factor (described in clause (iii)) for
16 such year multiplied by the geographic
17 index values computed for the fee
18 schedule area under subparagraph (A)
19 for the year (determined without re-
20 gard to this subparagraph).

21 “(ii) OLD WEIGHTING FACTOR.—The
22 old weighting factor described in this
23 clause—

24 “(I) for 2017, is $\frac{5}{6}$; and

1 “(II) for each succeeding year, is
2 the old weighting factor described in
3 this clause for the previous year
4 minus $\frac{1}{6}$.

5 “(iii) MSA-BASED WEIGHTING FAC-
6 TOR.—The MSA-based weighting factor
7 described in this clause for a year is 1
8 minus the old weighting factor under
9 clause (ii) for that year.

10 “(C) HOLD HARMLESS.—For services fur-
11 nished in a transition area in California during
12 a year beginning with 2017, the geographic
13 index values to be applied under this subsection
14 for such year shall not be less than the cor-
15 responding geographic index values that would
16 have applied in such transition area (as esti-
17 mated by the Secretary) if this paragraph did
18 not apply.

19 “(D) TRANSITION AREA DEFINED.—In
20 this paragraph, the term ‘transition area’
21 means each of the following fee schedule areas
22 for 2013:

23 “(i) The rest-of-State payment local-
24 ity.

25 “(ii) Payment locality 3.

1 “(E) REFERENCES TO FEE SCHEDULE
2 AREAS.—Effective for services furnished on or
3 after January 1, 2017, for California, any ref-
4 erence in this section to a fee schedule area
5 shall be deemed a reference to a fee schedule
6 area established in accordance with this para-
7 graph.”.

8 (2) CONFORMING AMENDMENT TO DEFINITION
9 OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the
10 Social Security Act (42 U.S.C. 1395w-4(j)(2)) is
11 amended by striking “The term” and inserting “Ex-
12 cept as provided in subsection (e)(6)(D), the term”.

13 (i) DISCLOSURE OF DATA USED TO ESTABLISH
14 MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—
15 The Secretary of Health and Human Services shall make
16 publicly available the information used to establish the
17 multiple procedure payment reduction policy to the profes-
18 sional component of imaging services in the final rule pub-
19 lished in the Federal Register, v. 77, n. 222, November
20 16, 2012, pages 68891–69380 under the physician fee
21 schedule under section 1848 of the Social Security Act (42
22 U.S.C. 1395w-4).

1 **SEC. 105. PROMOTING EVIDENCE-BASED CARE.**

2 (a) IN GENERAL.—Section 1834 of the Social Secu-
3 rity Act (42 U.S.C. 1395m) is amended by adding at the
4 end the following new subsection:

5 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR
6 CERTAIN IMAGING SERVICES.—

7 “(1) PROGRAM ESTABLISHED.—

8 “(A) IN GENERAL.—The Secretary shall
9 establish a program to promote the use of ap-
10 propriate use criteria (as defined in subpara-
11 graph (B)) for applicable imaging services (as
12 defined in subparagraph (C)) furnished in an
13 applicable setting (as defined in subparagraph
14 (D)) by ordering professionals and furnishing
15 professionals (as defined in subparagraphs (E)
16 and (F), respectively).

17 “(B) APPROPRIATE USE CRITERIA DE-
18 FINED.—In this subsection, the term ‘appro-
19 priate use criteria’ means criteria, only devel-
20 oped or endorsed by national professional med-
21 ical specialty societies or other provider-led enti-
22 ties, to assist ordering professionals and fur-
23 nishing professionals in making the most appro-
24 priate treatment decision for a specific clinical
25 condition. To the extent feasible, such criteria
26 shall be evidence-based.

1 “(C) APPLICABLE IMAGING SERVICE DE-
2 FINED.—In this subsection, the term ‘applicable
3 imaging service’ means an advanced diagnostic
4 imaging service (as defined in subsection
5 (e)(1)(B)) for which the Secretary determines—

6 “(i) one or more applicable appro-
7 priate use criteria specified under para-
8 graph (2) apply;

9 “(ii) there are one or more qualified
10 clinical decision support mechanisms listed
11 under paragraph (3)(C); and

12 “(iii) one or more of such mechanisms
13 is available free of charge.

14 “(D) APPLICABLE SETTING DEFINED.—In
15 this subsection, the term ‘applicable setting’
16 means a physician’s office, a hospital outpatient
17 department (including an emergency depart-
18 ment), an ambulatory surgical center, and any
19 other provider-led outpatient setting determined
20 appropriate by the Secretary.

21 “(E) ORDERING PROFESSIONAL DE-
22 FINED.—In this subsection, the term ‘ordering
23 professional’ means a physician (as defined in
24 section 1861(r)) or a practitioner described in

1 section 1842(b)(18)(C) who orders an applica-
2 ble imaging service for an individual.

3 “(F) FURNISHING PROFESSIONAL DE-
4 FINED.—In this subsection, the term ‘fur-
5 nishing professional’ means a physician (as de-
6 fined in section 1861(r)) or a practitioner de-
7 scribed in section 1842(b)(18)(C) who furnishes
8 an applicable imaging service for an individual.

9 “(2) ESTABLISHMENT OF APPLICABLE APPRO-
10 PRIATE USE CRITERIA.—

11 “(A) IN GENERAL.—Not later than No-
12 vember 15, 2015, the Secretary shall through
13 rulemaking, and in consultation with physi-
14 cians, practitioners, and other stakeholders,
15 specify applicable appropriate use criteria for
16 applicable imaging services only from among
17 appropriate use criteria developed or endorsed
18 by national professional medical specialty soci-
19 eties or other provider-led entities.

20 “(B) CONSIDERATIONS.—In specifying ap-
21 plicable appropriate use criteria under subpara-
22 graph (A), the Secretary shall take into account
23 whether the criteria—

24 “(i) have stakeholder consensus;

1 “(ii) are scientifically valid and evi-
2 dence based; and

3 “(iii) are based on studies that are
4 published and reviewable by stakeholders.

5 “(C) REVISIONS.—The Secretary shall re-
6 view, on an annual basis, the specified applica-
7 ble appropriate use criteria to determine if
8 there is a need to update or revise (as appro-
9 priate) such specification of applicable appro-
10 priate use criteria and make such updates or
11 revisions through rulemaking.

12 “(D) TREATMENT OF MULTIPLE APPLICA-
13 BLE APPROPRIATE USE CRITERIA.—In the case
14 where the Secretary determines that more than
15 one appropriate use criteria applies with respect
16 to an applicable imaging service, the Secretary
17 shall permit one or more applicable appropriate
18 use criteria under this paragraph for the serv-
19 ice.

20 “(3) MECHANISMS FOR CONSULTATION WITH
21 APPLICABLE APPROPRIATE USE CRITERIA.—

22 “(A) IDENTIFICATION OF MECHANISMS TO
23 CONSULT WITH APPLICABLE APPROPRIATE USE
24 CRITERIA.—

1 “(i) IN GENERAL.—The Secretary
2 shall specify qualified clinical decision sup-
3 port mechanisms that could be used by or-
4 dering professionals to consult with appli-
5 cable appropriate use criteria for applicable
6 imaging services.

7 “(ii) CONSULTATION.—The Secretary
8 shall consult with physicians, practitioners,
9 health care technology experts, and other
10 stakeholders in specifying mechanisms
11 under this paragraph.

12 “(iii) INCLUSION OF CERTAIN MECHA-
13 NISMS.—Mechanisms specified under this
14 paragraph may include any or all of the
15 following that meet the requirements de-
16 scribed in subparagraph (B)(ii):

17 “(I) Use of clinical decision sup-
18 port modules in certified EHR tech-
19 nology (as defined in section
20 1848(o)(4)).

21 “(II) Use of private sector clin-
22 ical decision support mechanisms that
23 are independent from certified EHR
24 technology, which may include use of
25 clinical decision support mechanisms

1 available from medical specialty orga-
2 nizations.

3 “(III) Use of a clinical decision
4 support mechanism established by the
5 Secretary.

6 “(B) QUALIFIED CLINICAL DECISION SUP-
7 PORT MECHANISMS.—

8 “(i) IN GENERAL.—For purposes of
9 this subsection, a qualified clinical decision
10 support mechanism is a mechanism that
11 the Secretary determines meets the re-
12 quirements described in clause (ii).

13 “(ii) REQUIREMENTS.—The require-
14 ments described in this clause are the fol-
15 lowing:

16 “(I) The mechanism makes avail-
17 able to the ordering professional appli-
18 cable appropriate use criteria specified
19 under paragraph (2) and the sup-
20 porting documentation for the applica-
21 ble imaging service ordered.

22 “(II) In the case where there are
23 more than one applicable appropriate
24 use criteria specified under such para-
25 graph for an applicable imaging serv-

1 ice, the mechanism indicates the cri-
2 teria that it uses for the service.

3 “(III) The mechanism determines
4 the extent to which an applicable im-
5 aging service ordered is consistent
6 with the applicable appropriate use
7 criteria so specified.

8 “(IV) The mechanism generates
9 and provides to the ordering profes-
10 sional a certification or documentation
11 that documents that the qualified clin-
12 ical decision support mechanism was
13 consulted by the ordering professional.

14 “(V) The mechanism is updated
15 on a timely basis to reflect revisions
16 to the specification of applicable ap-
17 propriate use criteria under such
18 paragraph.

19 “(VI) The mechanism meets pri-
20 vacy and security standards under ap-
21 plicable provisions of law.

22 “(VII) The mechanism performs
23 such other functions as specified by
24 the Secretary, which may include a re-

1 requirement to provide aggregate feed-
2 back to the ordering professional.

3 “(C) LIST OF MECHANISMS FOR CON-
4 SULTATION WITH APPLICABLE APPROPRIATE
5 USE CRITERIA.—

6 “(i) INITIAL LIST.—Not later than
7 April 1, 2016, the Secretary shall publish
8 a list of mechanisms specified under this
9 paragraph.

10 “(ii) PERIODIC UPDATING OF LIST.—
11 The Secretary shall identify on an annual
12 basis the list of qualified clinical decision
13 support mechanisms specified under this
14 paragraph.

15 “(4) CONSULTATION WITH APPLICABLE APPRO-
16 PRIATE USE CRITERIA.—

17 “(A) CONSULTATION BY ORDERING PRO-
18 FESSIONAL.—Beginning with January 1, 2017,
19 subject to subparagraph (C), with respect to an
20 applicable imaging service ordered by an order-
21 ing professional that would be furnished in an
22 applicable setting and paid for under an appli-
23 cable payment system (as defined in subpara-
24 graph (D)), an ordering professional shall—

1 “(i) consult with a qualified decision
2 support mechanism listed under paragraph
3 (3)(C); and

4 “(ii) provide to the furnishing profes-
5 sional the information described in clauses
6 (i) through (iii) of subparagraph (B).

7 “(B) REPORTING BY FURNISHING PROFES-
8 SIONAL.—Beginning with January 1, 2017,
9 subject to subparagraph (C), with respect to an
10 applicable imaging service furnished in an ap-
11 plicable setting and paid for under an applica-
12 ble payment system (as defined in subpara-
13 graph (D)), payment for such service may only
14 be made if the claim for the service includes the
15 following:

16 “(i) Information about which qualified
17 clinical decision support mechanism was
18 consulted by the ordering professional for
19 the service.

20 “(ii) Information regarding—

21 “(I) whether the service ordered
22 would adhere to the applicable appro-
23 priate use criteria specified under
24 paragraph (2);

1 “(II) whether the service ordered
2 would not adhere to such criteria; or

3 “(III) whether such criteria was
4 not applicable to the service ordered.

5 “(iii) The national provider identifier
6 of the ordering professional (if different
7 from the furnishing professional).

8 “(C) EXCEPTIONS.—The provisions of sub-
9 paragraphs (A) and (B) and paragraph (6)(A)
10 shall not apply to the following:

11 “(i) EMERGENCY SERVICES.—An ap-
12 plicable imaging service ordered for an in-
13 dividual with an emergency medical condi-
14 tion (as defined in section 1867(e)(1)).

15 “(ii) INPATIENT SERVICES.—An appli-
16 cable imaging service ordered for an inpa-
17 tient and for which payment is made under
18 part A.

19 “(iii) ALTERNATIVE PAYMENT MOD-
20 ELS.—An applicable imaging service or-
21 dered by an ordering professional with re-
22 spect to an individual attributed to an al-
23 ternative payment model (as defined in
24 section 1833(z)(3)(C)).

1 “(iv) SIGNIFICANT HARDSHIP.—An
2 applicable imaging service ordered by an
3 ordering professional who the Secretary
4 may, on a case-by-case basis, exempt from
5 the application of such provisions if the
6 Secretary determines, subject to annual re-
7 newal, that consultation with applicable ap-
8 propriate use criteria would result in a sig-
9 nificant hardship, such as in the case of a
10 professional who practices in a rural area
11 without sufficient Internet access.

12 “(D) APPLICABLE PAYMENT SYSTEM DE-
13 FINED.—In this subsection, the term ‘applicable
14 payment system’ means the following:

15 “(i) The physician fee schedule estab-
16 lished under section 1848(b).

17 “(ii) The prospective payment system
18 for hospital outpatient department services
19 under section 1833(t).

20 “(iii) The ambulatory surgical center
21 payment systems under section 1833(i).

22 “(5) IDENTIFICATION OF OUTLIER ORDERING
23 PROFESSIONALS.—

24 “(A) IN GENERAL.—With respect to appli-
25 cable imaging services furnished beginning with

1 2017, the Secretary shall determine, on an an-
2 nual basis, no more than five percent of the
3 total number of ordering professionals who are
4 outlier ordering professionals.

5 “(B) OUTLIER ORDERING PROFES-
6 SIONALS.—The determination of an outlier or-
7 dering professional shall—

8 “(i) be based on low adherence to ap-
9 plicable appropriate use criteria specified
10 under paragraph (2), which may be based
11 on comparison to other ordering profes-
12 sionals; and

13 “(ii) include data for ordering profes-
14 sionals for whom prior authorization under
15 paragraph (6)(A) applies.

16 “(C) USE OF TWO YEARS OF DATA.—The
17 Secretary shall use two years of data to identify
18 outlier ordering professionals under this para-
19 graph.

20 “(D) PROCESS.—The Secretary shall es-
21 tablish a process for determining when an
22 outlier ordering professional is no longer an
23 outlier ordering professional.

24 “(E) CONSULTATION WITH STAKE-
25 HOLDERS.—The Secretary shall consult with

1 physicians, practitioners and other stakeholders
2 in developing methods to identify outlier order-
3 ing professionals under this paragraph.

4 “(6) PRIOR AUTHORIZATION FOR ORDERING
5 PROFESSIONALS WHO ARE OUTLIERS.—

6 “(A) IN GENERAL.—Beginning January 1,
7 2020, subject to paragraph (4)(C), with respect
8 to services furnished during a year, the Sec-
9 retary shall, for a period determined appro-
10 priate by the Secretary, apply prior authoriza-
11 tion for applicable imaging services that are or-
12 dered by an outlier ordering professional identi-
13 fied under paragraph (5).

14 “(B) APPROPRIATE USE CRITERIA IN
15 PRIOR AUTHORIZATION.—In applying prior au-
16 thorization under subparagraph (A), the Sec-
17 retary shall utilize only the applicable appro-
18 priate use criteria specified under this sub-
19 section.

20 “(C) FUNDING.—For purposes of carrying
21 out this paragraph, the Secretary shall provide
22 for the transfer, from the Federal Supple-
23 mentary Medical Insurance Trust Fund under
24 section 1841, of \$5,000,000 to the Centers for
25 Medicare & Medicaid Services Program Man-

1 agement Account for each of fiscal years 2019
2 through 2021. Amounts transferred under the
3 preceding sentence shall remain available until
4 expended.

5 “(7) CONSTRUCTION.—Nothing in this sub-
6 section shall be construed as granting the Secretary
7 the authority to develop or initiate the development
8 of clinical practice guidelines or appropriate use cri-
9 teria.”.

10 (b) CONFORMING AMENDMENT.—Section
11 1833(t)(16) of the Social Security Act (42 U.S.C.
12 1395l(t)(16)) is amended by adding at the end the fol-
13 lowing new subparagraph:

14 “(E) APPLICATION OF APPROPRIATE USE
15 CRITERIA FOR CERTAIN IMAGING SERVICES.—
16 For provisions relating to the application of ap-
17 propriate use criteria for certain imaging serv-
18 ices, see section 1834(p).”.

19 (c) REPORT ON EXPERIENCE OF IMAGING APPRO-
20 PRIATE USE CRITERIA PROGRAM.—Not later than 18
21 months after the date of the enactment of this Act, the
22 Comptroller General of the United States shall submit to
23 Congress a report that includes a description of the extent
24 to which appropriate use criteria could be used for other
25 services under part B of title XVIII of the Social Security

1 Act (42 U.S.C. 1395j et seq.), such as radiation therapy
2 and clinical diagnostic laboratory services.

3 **SEC. 106. EMPOWERING BENEFICIARY CHOICES THROUGH**
4 **ACCESS TO INFORMATION ON PHYSICIANS'**
5 **SERVICES.**

6 (a) IN GENERAL.—The Secretary shall make publicly
7 available on Physician Compare the information described
8 in subsection (b) with respect to eligible professionals.

9 (b) INFORMATION DESCRIBED.—The following infor-
10 mation, with respect to an eligible professional, is de-
11 scribed in this subsection:

12 (1) Information on the number of services fur-
13 nished by the eligible professional under part B of
14 title XVIII of the Social Security Act (42 U.S.C.
15 1395j et seq.), which may include information on the
16 most frequent services furnished or groupings of
17 services.

18 (2) Information on submitted charges and pay-
19 ments for services under such part.

20 (3) A unique identifier for the eligible profes-
21 sional that is available to the public, such as a na-
22 tional provider identifier.

23 (c) SEARCHABILITY.—The information made avail-
24 able under this section shall be searchable by at least the
25 following:

1 (1) The specialty or type of the eligible profes-
2 sional.

3 (2) Characteristics of the services furnished,
4 such as volume or groupings of services.

5 (3) The location of the eligible professional.

6 (d) DISCLOSURE.—The information made available
7 under this section shall indicate, where appropriate, that
8 publicized information may not be representative of the
9 eligible professional’s entire patient population, the variety
10 of services furnished by the eligible professional, or the
11 health conditions of individuals treated.

12 (e) IMPLEMENTATION.—

13 (1) INITIAL IMPLEMENTATION.—Physician
14 Compare shall include the information described in
15 subsection (b)—

16 (A) with respect to physicians, by not later
17 than July 1, 2015; and

18 (B) with respect to other eligible profes-
19 sionals, by not later than July 1, 2016.

20 (2) ANNUAL UPDATING.—The information
21 made available under this section shall be updated
22 on Physician Compare not less frequently than on
23 an annual basis.

24 (f) OPPORTUNITY TO REVIEW AND SUBMIT CORREC-
25 TIONS.—The Secretary shall provide for an opportunity

1 for an eligible professional to review, and submit correc-
2 tions for, the information to be made public with respect
3 to the eligible professional under this section prior to such
4 information being made public.

5 (g) DEFINITIONS.—In this section:

6 (1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SEC-
7 RETARY.—The terms “eligible professional”, “physi-
8 cian”, and “Secretary” have the meaning given such
9 terms in section 10331(i) of Public Law 111–148.

10 (2) PHYSICIAN COMPARE.—The term “Physi-
11 cian Compare” means the Physician Compare Inter-
12 net website of the Centers for Medicare & Medicaid
13 Services (or a successor website).

14 **SEC. 107. EXPANDING AVAILABILITY OF MEDICARE DATA.**

15 (a) EXPANDING USES OF MEDICARE DATA BY
16 QUALIFIED ENTITIES.—

17 (1) ADDITIONAL ANALYSES.—

18 (A) IN GENERAL.—Subject to subpara-
19 graph (B), to the extent consistent with appli-
20 cable information, privacy, security, and disclo-
21 sure laws (including paragraph (3)), notwith-
22 standing paragraph (4)(B) of section 1874(e) of
23 the Social Security Act (42 U.S.C. 1395kk(e))
24 and the second sentence of paragraph (4)(D) of
25 such section, beginning July 1, 2015, a quali-

1 fied entity may use the combined data described
2 in paragraph (4)(B)(iii) of such section received
3 by such entity under such section, and informa-
4 tion derived from the evaluation described in
5 such paragraph (4)(D), to conduct additional
6 non-public analyses (as determined appropriate
7 by the Secretary) and provide or sell such anal-
8 yses to authorized users for non-public use (in-
9 cluding for the purposes of assisting providers
10 of services and suppliers to develop and partici-
11 pate in quality and patient care improvement
12 activities, including developing new models of
13 care).

14 (B) LIMITATIONS WITH RESPECT TO ANAL-
15 YSES.—

16 (i) EMPLOYERS.—Any analyses pro-
17 vided or sold under subparagraph (A) to
18 an employer described in paragraph
19 (9)(A)(iii) may only be used by such em-
20 ployer for purposes of providing health in-
21 surance to employees and retirees of the
22 employer.

23 (ii) HEALTH INSURANCE ISSUERS.—A
24 qualified entity may not provide or sell an
25 analysis to a health insurance issuer de-

1 scribed in paragraph (9)(A)(iv) unless the
2 issuer is providing the qualified entity with
3 data under section 1874(e)(4)(B)(iii) of
4 the Social Security Act (42 U.S.C.
5 1395kk(e)(4)(B)(iii)).

6 (2) ACCESS TO CERTAIN DATA.—

7 (A) ACCESS.—To the extent consistent
8 with applicable information, privacy, security,
9 and disclosure laws (including paragraph (3)),
10 notwithstanding paragraph (4)(B) of section
11 1874(e) of the Social Security Act (42 U.S.C.
12 1395kk(e)) and the second sentence of para-
13 graph (4)(D) of such section, beginning July 1,
14 2015, a qualified entity may—

15 (i) provide or sell the combined data
16 described in paragraph (4)(B)(iii) of such
17 section to authorized users described in
18 clauses (i), (ii), and (v) of paragraph
19 (9)(A) for non-public use, including for the
20 purposes described in subparagraph (B);
21 or

22 (ii) subject to subparagraph (C), pro-
23 vide Medicare claims data to authorized
24 users described in clauses (i), (ii), and (v),
25 of paragraph (9)(A) for non-public use, in-

1 cluding for the purposes described in sub-
2 paragraph (B).

3 (B) PURPOSES DESCRIBED.—The purposes
4 described in this subparagraph are assisting
5 providers of services and suppliers in developing
6 and participating in quality and patient care
7 improvement activities, including developing
8 new models of care.

9 (C) MEDICARE CLAIMS DATA MUST BE
10 PROVIDED AT NO COST.—A qualified entity may
11 not charge a fee for providing the data under
12 subparagraph (A)(ii).

13 (3) PROTECTION OF INFORMATION.—

14 (A) IN GENERAL.—Except as provided in
15 subparagraph (B), an analysis or data that is
16 provided or sold under paragraph (1) or (2)
17 shall not contain information that individually
18 identifies a patient.

19 (B) INFORMATION ON PATIENTS OF THE
20 PROVIDER OF SERVICES OR SUPPLIER.—To the
21 extent consistent with applicable information,
22 privacy, security, and disclosure laws, an anal-
23 ysis or data that is provided or sold to a pro-
24 vider of services or supplier under paragraph
25 (1) or (2) may contain information that individ-

1 usually identifies a patient of such provider or
2 supplier, including with respect to items and
3 services furnished to the patient by other pro-
4 viders of services or suppliers.

5 (C) PROHIBITION ON USING ANALYSES OR
6 DATA FOR MARKETING PURPOSES.—An author-
7 ized user shall not use an analysis or data pro-
8 vided or sold under paragraph (1) or (2) for
9 marketing purposes.

10 (4) DATA USE AGREEMENT.—A qualified entity
11 and an authorized user described in clauses (i), (ii),
12 and (v) of paragraph (9)(A) shall enter into an
13 agreement regarding the use of any data that the
14 qualified entity is providing or selling to the author-
15 ized user under paragraph (2). Such agreement shall
16 describe the requirements for privacy and security of
17 the data and, as determined appropriate by the Sec-
18 retary, any prohibitions on using such data to link
19 to other individually identifiable sources of informa-
20 tion. If the authorized user is not a covered entity
21 under the rules promulgated pursuant to the Health
22 Insurance Portability and Accountability Act of
23 1996, the agreement shall identify the relevant regu-
24 lations, as determined by the Secretary, that the

1 user shall comply with as if it were acting in the ca-
2 pacity of such a covered entity.

3 (5) NO REDISCLOSURE OF ANALYSES OR
4 DATA.—

5 (A) IN GENERAL.—Except as provided in
6 subparagraph (B), an authorized user that is
7 provided or sold an analysis or data under
8 paragraph (1) or (2) shall not redisclose or
9 make public such analysis or data or any anal-
10 ysis using such data.

11 (B) PERMITTED REDISCLOSURE.—A pro-
12 vider of services or supplier that is provided or
13 sold an analysis or data under paragraph (1) or
14 (2) may, as determined by the Secretary, redis-
15 close such analysis or data for the purposes of
16 performance improvement and care coordination
17 activities but shall not make public such anal-
18 ysis or data or any analysis using such data.

19 (6) OPPORTUNITY FOR PROVIDERS OF SERV-
20 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-
21 fied entity providing or selling an analysis to an au-
22 thorized user under paragraph (1), to the extent
23 that such analysis would individually identify a pro-
24 vider of services or supplier who is not being pro-
25 vided or sold such analysis, such qualified entity

1 shall provide such provider or supplier with the op-
2 portunity to appeal and correct errors in the manner
3 described in section 1874(e)(4)(C)(ii) of the Social
4 Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

5 (7) ASSESSMENT FOR A BREACH.—

6 (A) IN GENERAL.—In the case of a breach
7 of a data use agreement under this section or
8 section 1874(e) of the Social Security Act (42
9 U.S.C. 1395kk(e)), the Secretary shall impose
10 an assessment on the qualified entity both in
11 the case of—

12 (i) an agreement between the Sec-
13 retary and a qualified entity; and

14 (ii) an agreement between a qualified
15 entity and an authorized user.

16 (B) ASSESSMENT.—The assessment under
17 subparagraph (A) shall be an amount up to
18 \$100 for each individual entitled to, or enrolled
19 for, benefits under part A of title XVIII of the
20 Social Security Act or enrolled for benefits
21 under part B of such title—

22 (i) in the case of an agreement de-
23 scribed in subparagraph (A)(i), for whom
24 the Secretary provided data on to the
25 qualified entity under paragraph (2); and

1 (ii) in the case of an agreement de-
2 scribed in subparagraph (A)(ii), for whom
3 the qualified entity provided data on to the
4 authorized user under paragraph (2).

5 (C) DEPOSIT OF AMOUNTS COLLECTED.—

6 Any amounts collected pursuant to this para-
7 graph shall be deposited in Federal Supple-
8 mentary Medical Insurance Trust Fund under
9 section 1841 of the Social Security Act (42
10 U.S.C. 1395t).

11 (8) ANNUAL REPORTS.—Any qualified entity
12 that provides or sells an analysis or data under
13 paragraph (1) or (2) shall annually submit to the
14 Secretary a report that includes—

15 (A) a summary of the analyses provided or
16 sold, including the number of such analyses, the
17 number of purchasers of such analyses, and the
18 total amount of fees received for such analyses;

19 (B) a description of the topics and pur-
20 poses of such analyses;

21 (C) information on the entities who re-
22 ceived the data under paragraph (2), the uses
23 of the data, and the total amount of fees re-
24 ceived for providing, selling, or sharing the
25 data; and

1 (D) other information determined appro-
2 priate by the Secretary.

3 (9) DEFINITIONS.—In this subsection and sub-
4 section (b):

5 (A) AUTHORIZED USER.—The term “au-
6 thorized user” means the following:

7 (i) A provider of services.

8 (ii) A supplier.

9 (iii) An employer (as defined in sec-
10 tion 3(5) of the Employee Retirement In-
11 surance Security Act of 1974).

12 (iv) A health insurance issuer (as de-
13 fined in section 2791 of the Public Health
14 Service Act).

15 (v) A medical society or hospital asso-
16 ciation.

17 (vi) Any entity not described in
18 clauses (i) through (v) that is approved by
19 the Secretary (other than an employer or
20 health insurance issuer not described in
21 clauses (iii) and (iv), respectively, as deter-
22 mined by the Secretary).

23 (B) PROVIDER OF SERVICES.—The term
24 “provider of services” has the meaning given

1 such term in section 1861(u) of the Social Se-
2 curity Act (42 U.S.C. 1395x(u)).

3 (C) QUALIFIED ENTITY.—The term “quali-
4 fied entity” has the meaning given such term in
5 section 1874(e)(2) of the Social Security Act
6 (42 U.S.C. 1395kk(e)).

7 (D) SECRETARY.—The term “Secretary”
8 means the Secretary of Health and Human
9 Services.

10 (E) SUPPLIER.—The term “supplier” has
11 the meaning given such term in section 1861(d)
12 of the Social Security Act (42 U.S.C.
13 1395x(d)).

14 (b) ACCESS TO MEDICARE DATA BY QUALIFIED
15 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY
16 IMPROVEMENT.—

17 (1) ACCESS.—

18 (A) IN GENERAL.—To the extent con-
19 sistent with applicable information, privacy, se-
20 curity, and disclosure laws, beginning July 1,
21 2015, the Secretary shall, at the request of a
22 qualified clinical data registry under section
23 1848(m)(3)(E) of the Social Security Act (42
24 U.S.C. 1395w-4(m)(3)(E)), provide the data
25 described in subparagraph (B) (in a form and

1 manner determined to be appropriate) to such
2 qualified clinical data registry for purposes of
3 linking such data with clinical outcomes data
4 and performing risk-adjusted, scientifically valid
5 analyses and research to support quality im-
6 provement or patient safety, provided that any
7 public reporting of such analyses or research
8 that identifies a provider of services or supplier
9 shall only be conducted with the opportunity of
10 such provider or supplier to appeal and correct
11 errors in the manner described in subsection
12 (a)(6).

13 (B) DATA DESCRIBED.—The data de-
14 scribed in this subparagraph is—

15 (i) claims data under the Medicare
16 program under title XVIII of the Social
17 Security Act; and

18 (ii) if the Secretary determines appro-
19 priate, claims data under the Medicaid
20 program under title XIX of such Act and
21 the State Children’s Health Insurance Pro-
22 gram under title XXI of such Act.

23 (2) FEE.—Data described in paragraph (1)(B)
24 shall be provided to a qualified clinical data registry
25 under paragraph (1) at a fee equal to the cost of

1 providing such data. Any fee collected pursuant to
2 the preceding sentence shall be deposited in the Cen-
3 ters for Medicare & Medicaid Services Program
4 Management Account.

5 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED
6 ENTITIES.—Section 1874(e) of the Social Security Act
7 (42 U.S.C. 1395kk(e)) is amended—

8 (1) in the subsection heading, by striking
9 “MEDICARE”; and

10 (2) in paragraph (3)—

11 (A) by inserting after the first sentence the
12 following new sentence: “Beginning July 1,
13 2015, if the Secretary determines appropriate,
14 the data described in this paragraph may also
15 include standardized extracts (as determined by
16 the Secretary) of claims data under titles XIX
17 and XXI for assistance provided under such ti-
18 tles for one or more specified geographic areas
19 and time periods requested by a qualified enti-
20 ty.”; and

21 (B) in the last sentence, by inserting “or
22 under titles XIX or XXI” before the period at
23 the end.

1 (d) REVISION OF PLACEMENT OF FEES.—Section
 2 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
 3 1395kk(e)(4)(A)) is amended, in the second sentence—

4 (1) by inserting “, for periods prior to July 1,
 5 2015,” after “deposited”; and

6 (2) by inserting the following before the period
 7 at the end: “, and, beginning July 1, 2015, into the
 8 Centers for Medicare & Medicaid Services Program
 9 Management Account”.

10 **SEC. 108. REDUCING ADMINISTRATIVE BURDEN AND**
 11 **OTHER PROVISIONS.**

12 (a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-
 13 OUT TO PRIVATE CONTRACT.—

14 (1) INDEFINITE, CONTINUING AUTOMATIC EX-
 15 TENSION OF OPT OUT ELECTION.—

16 (A) IN GENERAL.—Section 1802(b)(3) of
 17 the Social Security Act (42 U.S.C. 1395a(b)(3))
 18 is amended—

19 (i) in subparagraph (B)(ii), by strik-
 20 ing “during the 2-year period beginning on
 21 the date the affidavit is signed” and insert-
 22 ing “during the applicable 2-year period
 23 (as defined in subparagraph (D))”;

24 (ii) in subparagraph (C), by striking
 25 “during the 2-year period described in sub-

1 paragraph (B)(ii)” and inserting “during
2 the applicable 2-year period”; and

3 (iii) by adding at the end the fol-
4 lowing new subparagraph:

5 “(D) APPLICABLE 2-YEAR PERIODS FOR
6 EFFECTIVENESS OF AFFIDAVITS.—In this sub-
7 section, the term ‘applicable 2-year period’
8 means, with respect to an affidavit of a physi-
9 cian or practitioner under subparagraph (B),
10 the 2-year period beginning on the date the af-
11 fidavit is signed and includes each subsequent
12 2-year period unless the physician or practi-
13 tioner involved provides notice to the Secretary
14 (in a form and manner specified by the Sec-
15 retary), not later than 30 days before the end
16 of the previous 2-year period, that the physician
17 or practitioner does not want to extend the ap-
18 plication of the affidavit for such subsequent 2-
19 year period.”.

20 (B) EFFECTIVE DATE.—The amendments
21 made by subparagraph (A) shall apply to affi-
22 davits entered into on or after the date that is
23 60 days after the date of the enactment of this
24 Act.

1 (2) PUBLIC AVAILABILITY OF INFORMATION ON
2 OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section
3 1802(b) of the Social Security Act (42 U.S.C.
4 1395a(b)) is amended—

5 (A) in paragraph (5), by adding at the end
6 the following new subparagraph:

7 “(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—
8 The term ‘opt-out physician or practitioner’ means
9 a physician or practitioner who has in effect an affi-
10 davit under paragraph (3)(B).”;

11 (B) by redesignating paragraph (5) as
12 paragraph (6); and

13 (C) by inserting after paragraph (4) the
14 following new paragraph:

15 “(5) POSTING OF INFORMATION ON OPT-OUT
16 PHYSICIANS AND PRACTITIONERS.—

17 “(A) IN GENERAL.—Beginning not later
18 than February 1, 2015, the Secretary shall
19 make publicly available through an appropriate
20 publicly accessible website of the Department of
21 Health and Human Services information on the
22 number and characteristics of opt-out physi-
23 cians and practitioners and shall update such
24 information on such website not less often than
25 annually.

1 “(B) INFORMATION TO BE INCLUDED.—

2 The information to be made available under
3 subparagraph (A) shall include at least the fol-
4 lowing with respect to opt-out physicians and
5 practitioners:

6 “(i) Their number.

7 “(ii) Their physician or professional
8 specialty or other designation.

9 “(iii) Their geographic distribution.

10 “(iv) The timing of their becoming
11 opt-out physicians and practitioners, rel-
12 ative to when they first entered practice
13 and with respect to applicable 2-year peri-
14 ods.

15 “(v) The proportion of such physi-
16 cians and practitioners who billed for
17 emergency or urgent care services.”.

18 (b) GAINSHARING STUDY AND REPORT.—Not later
19 than 6 months after the date of the enactment of this Act,
20 the Secretary of Health and Human Services, in consulta-
21 tion with the Inspector General of the Department of
22 Health and Human Services, shall submit to Congress a
23 report with legislative recommendations to amend existing
24 fraud and abuse laws, through exceptions, safe harbors,
25 or other narrowly targeted provisions, to permit

1 gainsharing or similar arrangements between physicians
2 and hospitals that improve care while reducing waste and
3 increasing efficiency. The report shall—

4 (1) consider whether such provisions should
5 apply to ownership interests, compensation arrange-
6 ments, or other relationships;

7 (2) describe how the recommendations address
8 accountability, transparency, and quality, including
9 how best to limit inducements to stint on care, dis-
10 charge patients prematurely, or otherwise reduce or
11 limit medically necessary care; and

12 (3) consider whether a portion of any savings
13 generated by such arrangements should accrue to
14 the Medicare program under title XVIII of the So-
15 cial Security Act.

16 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC
17 HEALTH RECORD SYSTEMS.—

18 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-
19 SPREAD EHR INTEROPERABILITY.—

20 (A) OBJECTIVE.—As a consequence of a
21 significant Federal investment in the implemen-
22 tation of health information technology through
23 the Medicare and Medicaid EHR incentive pro-
24 grams, Congress declares it a national objective
25 to achieve widespread exchange of health infor-

1 mation through interoperable certified EHR
2 technology nationwide by December 31, 2017.

3 (B) DEFINITIONS.—In this paragraph:

4 (i) WIDESPREAD INTEROPER-
5 ABILITY.—The term “widespread inter-
6 operability” means interoperability between
7 certified EHR technology systems em-
8 ployed by meaningful EHR users under
9 the Medicare and Medicaid EHR incentive
10 programs and other clinicians and health
11 care providers on a nationwide basis.

12 (ii) INTEROPERABILITY.—The term
13 “interoperability” means the ability of two
14 or more health information systems or
15 components to exchange clinical and other
16 information and to use the information
17 that has been exchanged using common
18 standards as to provide access to longitu-
19 dinal information for health care providers
20 in order to facilitate coordinated care and
21 improved patient outcomes.

22 (C) ESTABLISHMENT OF METRICS.—Not
23 later than July 1, 2015, and in consultation
24 with stakeholders, the Secretary shall establish
25 metrics to be used to determine if and to the

1 extent that the objective described in subpara-
2 graph (A) has been achieved.

3 (D) RECOMMENDATIONS IF OBJECTIVE
4 NOT ACHIEVED.—If the Secretary of Health
5 and Human Services determines that the objec-
6 tive described in subparagraph (A) has not been
7 achieved by December 31, 2017, then the Sec-
8 retary shall submit to Congress a report, by not
9 later than December 31, 2018, that identifies
10 barriers to such objective and recommends ac-
11 tions that the Federal Government can take to
12 achieve such objective. Such recommended ac-
13 tions may include recommendations—

14 (i) to adjust payments for not being
15 meaningful EHR users under the Medicare
16 EHR incentive programs; and

17 (ii) for criteria for decertifying cer-
18 tified EHR technology products.

19 (2) PREVENTING BLOCKING THE SHARING OF
20 INFORMATION.—

21 (A) FOR MEANINGFUL EHR PROFES-
22 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-
23 cial Security Act (42 U.S.C. 1395w-
24 4(o)(2)(A)(ii)) is amended by inserting before
25 the period at the end the following: “, and the

1 professional demonstrates (through a process
2 specified by the Secretary, such as the use of an
3 attestation) that the professional has not know-
4 ingly and willfully taken any action to limit or
5 restrict the compatibility or interoperability of
6 the certified EHR technology”.

7 (B) FOR MEANINGFUL EHR HOSPITALS.—
8 Section 1886(n)(3)(A)(ii) of the Social Security
9 Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amend-
10 ed by inserting before the period at the end the
11 following: “, and the hospital demonstrates
12 (through a process specified by the Secretary,
13 such as the use of an attestation) that the hos-
14 pital has not knowingly and willfully taken any
15 action to limit or restrict the compatibility or
16 interoperability of the certified EHR tech-
17 nology”.

18 (C) EFFECTIVE DATE.—The amendments
19 made by this subsection shall apply to meaning-
20 ful EHR users as of the date that is one year
21 after the date of the enactment of this Act.

22 (3) STUDY AND REPORT ON THE FEASIBILITY
23 OF ESTABLISHING A WEBSITE TO COMPARE CER-
24 TIFIED EHR TECHNOLOGY PRODUCTS.—

1 (A) STUDY.—The Secretary shall conduct
2 a study to examine the feasibility of estab-
3 lishing mechanisms that includes aggregated re-
4 sults of surveys of meaningful EHR users on
5 the functionality of certified EHR technology
6 products to enable such users to directly com-
7 pare the functionality and other features of
8 such products. Such information may be made
9 available through contracts with physician, hos-
10 pital, or other organizations that maintain such
11 comparative information.

12 (B) REPORT.—Not later than 1 year after
13 the date of the enactment of this Act, the Sec-
14 retary shall submit to Congress a report on the
15 website. The report shall include information on
16 the benefits of, and resources needed to develop
17 and maintain, such a website.

18 (4) DEFINITIONS.—In this subsection:

19 (A) The term “certified EHR technology”
20 has the meaning given such term in section
21 1848(o)(4) of the Social Security Act (42
22 U.S.C. 1395w–4(o)(4)).

23 (B) The term “meaningful EHR user” has
24 the meaning given such term under the Medi-
25 care EHR incentive programs.

1 (C) The term “Medicare and Medicaid
2 EHR incentive programs” means—

3 (i) in the case of the Medicare pro-
4 gram under title XVIII of the Social Secu-
5 rity Act, the incentive programs under sec-
6 tion 1814(l)(3), section 1848(o), sub-
7 sections (l) and (m) of section 1853, and
8 section 1886(n) of the Social Security Act
9 (42 U.S.C. 1395f(l)(3), 1395w-4(o),
10 1395w-23, 1395ww(n)); and

11 (ii) in the case of the Medicaid pro-
12 gram under title XIX of such Act, the in-
13 centive program under subsections
14 (a)(3)(F) and (t) of section 1903 of such
15 Act (42 U.S.C. 1396b).

16 (D) The term “Secretary” means the Sec-
17 retary of Health and Human Services.

18 (d) GAO STUDIES AND REPORTS ON THE USE OF
19 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-
20 MOTE PATIENT MONITORING SERVICES.—

21 (1) STUDY ON TELEHEALTH SERVICES.—The
22 Comptroller General of the United States shall con-
23 duct a study on the following:

24 (A) How the definition of telehealth across
25 various Federal programs and Federal efforts

1 can inform the use of telehealth in the Medicare
2 program under title XVIII of the Social Secu-
3 rity Act (42 U.S.C. 1395 et seq.).

4 (B) Issues that can facilitate or inhibit the
5 use of telehealth under the Medicare program
6 under such title, including oversight and profes-
7 sional licensure, changing technology, privacy
8 and security, infrastructure requirements, and
9 varying needs across urban and rural areas.

10 (C) Potential implications of greater use of
11 telehealth with respect to payment and delivery
12 system transformations under the Medicare
13 program under such title XVIII and the Med-
14 icaid program under title XIX of such Act (42
15 U.S.C. 1396 et seq.).

16 (D) How the Centers for Medicare & Med-
17 icaid Services conducts oversight of payments
18 made under the Medicare program under such
19 title XVIII to providers for telehealth services.

20 (2) STUDY ON REMOTE PATIENT MONITORING
21 SERVICES.—

22 (A) IN GENERAL.—The Comptroller Gen-
23 eral of the United States shall conduct a
24 study—

1 (i) of the dissemination of remote pa-
2 tient monitoring technology in the private
3 health insurance market;

4 (ii) of the financial incentives in the
5 private health insurance market relating to
6 adoption of such technology;

7 (iii) of the barriers to adoption of
8 such services under the Medicare program
9 under title XVIII of the Social Security
10 Act;

11 (iv) that evaluates the patients, condi-
12 tions, and clinical circumstances that could
13 most benefit from remote patient moni-
14 toring services; and

15 (v) that evaluates the challenges re-
16 lated to establishing appropriate valuation
17 for remote patient monitoring services
18 under the Medicare physician fee schedule
19 under section 1848 of the Social Security
20 Act (42 U.S.C. 1395w-4) in order to accu-
21 rately reflect the resources involved in fur-
22 nishing such services.

23 (B) DEFINITIONS.—For purposes of this
24 paragraph:

1 (i) REMOTE PATIENT MONITORING
2 SERVICES.—The term “remote patient
3 monitoring services” means services fur-
4 nished through remote patient monitoring
5 technology.

6 (ii) REMOTE PATIENT MONITORING
7 TECHNOLOGY.—The term “remote patient
8 monitoring technology” means a coordi-
9 nated system that uses one or more home-
10 based or mobile monitoring devices that
11 automatically transmit vital sign data or
12 information on activities of daily living and
13 may include responses to assessment ques-
14 tions collected on the devices wirelessly or
15 through a telecommunications connection
16 to a server that complies with the Federal
17 regulations (concerning the privacy of indi-
18 vidualy identifiable health information)
19 promulgated under section 264(c) of the
20 Health Insurance Portability and Account-
21 ability Act of 1996, as part of an estab-
22 lished plan of care for that patient that in-
23 cludes the review and interpretation of that
24 data by a health care professional.

1 (3) REPORTS.—Not later than 24 months after
2 the date of the enactment of this Act, the Comp-
3 troller General shall submit to Congress—

4 (A) a report containing the results of the
5 study conducted under paragraph (1); and

6 (B) a report containing the results of the
7 study conducted under paragraph (2).

8 A report required under this paragraph shall be sub-
9 mitted together with recommendations for such leg-
10 islation and administrative action as the Comptroller
11 General determines appropriate. The Comptroller
12 General may submit one report containing the re-
13 sults described in subparagraphs (A) and (B) and
14 the recommendations described in the previous sen-
15 tence.

16 (e) RULE OF CONSTRUCTION REGARDING
17 HEALTHCARE PROVIDER STANDARDS OF CARE.—

18 (1) MAINTENANCE OF STATE STANDARDS.—

19 The development, recognition, or implementation of
20 any guideline or other standard under any Federal
21 health care provision shall not be construed—

22 (A) to establish the standard of care or
23 duty of care owed by a health care provider to
24 a patient in any medical malpractice or medical
25 product liability action or claim; or

1 (B) to preempt any standard of care or
2 duty of care, owed by a health care provider to
3 a patient, duly established under State or com-
4 mon law.

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

7 (A) FEDERAL HEALTH CARE PROVISION.—
8 The term “Federal health care provision”
9 means any provision of the Patient Protection
10 and Affordable Care Act (Public Law 111–
11 148), title I or subtitle B of title II of the
12 Health Care and Education Reconciliation Act
13 of 2010 (Public Law 111–152), or title XVIII
14 or XIX of the Social Security Act.

15 (B) HEALTH CARE PROVIDER.—The term
16 “health care provider” means any individual or
17 entity—

18 (i) licensed, registered, or certified
19 under Federal or State laws or regulations
20 to provide health care services; or

21 (ii) required to be so licensed, reg-
22 istered, or certified but that is exempted
23 by other statute or regulation.

24 (C) MEDICAL MALPRACTICE OR MEDICAL
25 PRODUCT LIABILITY ACTION OR CLAIM.—The

1 term “medical malpractice or medical product
2 liability action or claim” means a medical mal-
3 practice action or claim (as defined in section
4 431(7) of the Health Care Quality Improve-
5 ment Act of 1986 (42 U.S.C. 11151(7))) and
6 includes a liability action or claim relating to a
7 health care provider’s prescription or provision
8 of a drug, device, or biological product (as such
9 terms are defined in section 201 of the Federal
10 Food, Drug, and Cosmetic Act or section 351
11 of the Public Health Service Act).

12 (D) STATE.—The term “State” includes
13 the District of Columbia, Puerto Rico, and any
14 other commonwealth, possession, or territory of
15 the United States.

16 (3) PRESERVATION OF STATE LAW.—No provi-
17 sion of the Patient Protection and Affordable Care
18 Act (Public Law 111–148), title I or subtitle B of
19 title II of the Health Care and Education Reconcili-
20 ation Act of 2010 (Public Law 111–152), or title
21 XVIII or XIX of the Social Security Act shall be
22 construed to preempt any State or common law gov-
23 erning medical professional or medical product liabil-
24 ity actions or claims.

1 **TITLE II—EXTENSIONS**
2 **Subtitle A—Medicare Extensions**

3 **SEC. 201. WORK GEOGRAPHIC ADJUSTMENT.**

4 Section 1848(e)(1)(E) of the Social Security Act (42
5 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “and
6 before April 1, 2014,”.

7 **SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES.**

8 (a) **REPEAL OF THERAPY CAP AND 1-YEAR EXTEN-**
9 **SION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—**
10 Section 1833(g) of the Social Security Act (42 U.S.C.
11 1395l(g)) is amended—

12 (1) in paragraph (4)—

13 (A) by striking “This subsection” and in-
14 serting “Except as provided in paragraph
15 (5)(C)(iii), this subsection”; and

16 (B) by inserting the following before the
17 period at the end: “or with respect to services
18 furnished on or after the date of enactment of
19 the Medicare SGR Repeal and Beneficiary Ac-
20 cess Improvement Act of 2014”; and

21 (2) in paragraph (5)(C), by adding at the end
22 the following new clause:

23 “(iii) Beginning on the date of enactment of the
24 Medicare SGR Repeal and Beneficiary Access Improve-
25 ment Act of 2014 and ending on the day before the date

1 that is 12 months after such date of enactment, the man-
 2 ual medical review process described in clause (i) shall
 3 apply with respect to expenses incurred in a year for serv-
 4 ices described in paragraphs (1) and (3) that exceed the
 5 threshold described in clause (ii) for the year.”.

6 (b) MEDICAL REVIEW OF OUTPATIENT THERAPY
 7 SERVICES.—

8 (1) MEDICAL REVIEW OF OUTPATIENT THER-
 9 APY SERVICES.—Section 1833 of the Social Security
 10 Act (42 U.S.C. 1395l), as amended by section
 11 101(e)(2), is amended by adding at the end the fol-
 12 lowing new subsection:

13 “(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY
 14 SERVICES.—

15 “(1) IN GENERAL.—

16 “(A) PROCESS FOR MEDICAL REVIEW.—

17 The Secretary shall implement a process for the
 18 medical review (as described in paragraph (2))
 19 of outpatient therapy services (as defined in
 20 paragraph (10)) and, subject to paragraph
 21 (12), apply such process to such services fur-
 22 nished on or after the date that is 12 months
 23 after the date of enactment of the Medicare
 24 SGR Repeal and Beneficiary Access Improve-

1 ment Act of 2014, focusing on services identi-
2 fied under subparagraph (B).

3 “(B) IDENTIFICATION OF SERVICES FOR
4 REVIEW.—Under the process, the Secretary
5 shall identify services for medical review, using
6 such factors as the Secretary determines appro-
7 priate, which may include the following:

8 “(i) Services furnished by a therapy
9 provider (as defined in paragraph (10))
10 whose pattern of billing is aberrant com-
11 pared to peers.

12 “(ii) Services furnished by a therapy
13 provider who, in a prior period, has a high
14 claims denial percentage or is less compli-
15 ant with other applicable requirements
16 under this title.

17 “(iii) Services furnished by a therapy
18 provider that is newly enrolled under this
19 title.

20 “(iv) Services furnished by a therapy
21 provider who has questionable billing prac-
22 tices, such as billing medically unlikely
23 units of services in a day.

24 “(v) Services furnished to treat a type
25 of medical condition.

1 “(vi) Services identified by use of the
2 standardized data elements required to be
3 reported under section 1834(p).

4 “(vii) Services furnished by a single
5 therapy provider or a group that includes
6 a therapy provider identified by factors de-
7 scribed in this subparagraph.

8 “(viii) Other services as determined
9 appropriate by the Secretary.

10 “(2) MEDICAL REVIEW.—

11 “(A) PRIOR AUTHORIZATION MEDICAL RE-
12 VIEW.—

13 “(i) IN GENERAL.—Subject to the
14 succeeding provisions of this subparagraph,
15 the Secretary shall use prior authorization
16 medical review for outpatient therapy serv-
17 ices furnished to an individual above one
18 or more thresholds established by the Sec-
19 retary, such as a dollar threshold or a
20 threshold based on other factors.

21 “(ii) ENDING APPLICATION OF PRIOR
22 AUTHORIZATION FOR A THERAPY PRO-
23 VIDER.—The Secretary shall end the appli-
24 cation of prior authorization medical re-
25 view to outpatient therapy services fur-

1 nished by a therapy provider if the Sec-
2 retary determines that the provider has a
3 low denial rate under such prior authoriza-
4 tion. The Secretary may subsequently re-
5 apply prior authorization medical review to
6 such therapy provider if the Secretary de-
7 termines it to be appropriate.

8 “(iii) PRIOR AUTHORIZATION OF MUL-
9 TIPLE SERVICES.—The Secretary shall,
10 where practicable, provide for prior author-
11 ization medical review for multiple services
12 at a single time, such as services in a ther-
13 apy plan of care described in section
14 1861(p)(2).

15 “(B) OTHER TYPES OF MEDICAL RE-
16 VIEW.—The Secretary may use pre-payment re-
17 view or post-payment review for services identi-
18 fied under paragraph (1)(B) that are not sub-
19 ject to prior authorization medical review under
20 subparagraph (A).

21 “(C) LIMITATION FOR LAW ENFORCEMENT
22 ACTIVITIES.—The Secretary may determine
23 that medical review under this subsection does
24 not apply in the case where potential fraud may
25 be involved.

1 “(3) REVIEW CONTRACTORS.—The Secretary
2 shall conduct prior authorization medical review of
3 outpatient therapy services under this subsection
4 using medicare administrative contractors (as de-
5 scribed in section 1874A) or other review contrac-
6 tors (other than contractors under section 1893(h)
7 or contractors paid on a contingent basis).

8 “(4) NO PAYMENT WITHOUT PRIOR AUTHORIZA-
9 TION.—With respect to an outpatient therapy service
10 for which prior authorization medical review under
11 this subsection applies, the following shall apply:

12 “(A) PRIOR AUTHORIZATION DETERMINA-
13 TION.—The Secretary shall make a determina-
14 tion, prior to the service being furnished, of
15 whether the service would or would not meet
16 the applicable requirements of section
17 1862(a)(1)(A).

18 “(B) DENIAL OF PAYMENT.—Subject to
19 paragraph (6), no payment shall be made under
20 this part for the service unless the Secretary
21 determines pursuant to subparagraph (A) that
22 the service would meet the applicable require-
23 ments of such section.

24 “(5) SUBMISSION OF INFORMATION.—A ther-
25 apy provider may submit the information necessary

1 for medical review by fax, by mail, or by electronic
2 means. The Secretary shall make available the elec-
3 tronic means described in the preceding sentence as
4 soon as practicable, but not later than 24 months
5 after the date of enactment of this subsection.

6 “(6) TIMELINESS.—If the Secretary does not
7 make a prior authorization determination under
8 paragraph (4)(A) within 10 business days of the
9 date of the Secretary’s receipt of medical docu-
10 mentation needed to make such determination, para-
11 graph (4)(B) shall not apply.

12 “(7) CONSTRUCTION.—With respect to an out-
13 patient therapy service that has been affirmed by
14 medical review under this subsection, nothing in this
15 subsection shall be construed to preclude the subse-
16 quent denial of a claim for such service that does
17 not meet other applicable requirements under this
18 Act.

19 “(8) BENEFICIARY PROTECTIONS.—With re-
20 spect to services furnished on or after January 1,
21 2015, where payment may not be made as a result
22 of application of medical review under this sub-
23 section, section 1879 shall apply in the same manner
24 as such section applies to a denial that is made by
25 reason of section 1862(a)(1).

1 “(9) IMPLEMENTATION.—

2 “(A) AUTHORITY.—The Secretary may im-
3 plement the provisions of this subsection by in-
4 terim final rule with comment period.

5 “(B) ADMINISTRATION.—Chapter 35 of
6 title 44, United States Code, shall not apply to
7 medical review under this subsection.

8 “(C) LIMITATION.—There shall be no ad-
9 ministrative or judicial review under section
10 1869, section 1878, or otherwise of the identi-
11 fication of services for medical review or the
12 process for medical review under this sub-
13 section.

14 “(10) DEFINITIONS.—For purposes of this sub-
15 section:

16 “(A) OUTPATIENT THERAPY SERVICES.—
17 The term ‘outpatient therapy services’ means
18 the following services for which payment is
19 made under section 1848, 1834(g), or 1834(k):

20 “(i) Physical therapy services of the
21 type described in section 1861(p).

22 “(ii) Speech-language pathology serv-
23 ices of the type described in such section
24 though the application of section
25 1861(ll)(2).

1 “(iii) Occupational therapy services of
2 the type described in section 1861(p)
3 through the operation of section 1861(g).

4 “(B) THERAPY PROVIDER.—The term
5 ‘therapy provider’ means a provider of services
6 (as defined in section 1861(u)) or a supplier (as
7 defined in section 1861(d)) who submits a claim
8 for outpatient therapy services.

9 “(11) FUNDING.—For purposes of imple-
10 menting this subsection, the Secretary shall provide
11 for the transfer, from the Federal Supplementary
12 Medical Insurance Trust Fund under section 1841,
13 of \$35,000,000 to the Centers for Medicare & Med-
14 icaid Services Program Management Account for
15 each fiscal year (beginning with fiscal year 2014).
16 Amounts transferred under this paragraph shall re-
17 main available until expended.

18 “(12) SCALING BACK.—

19 “(A) PERIODIC DETERMINATIONS.—Begin-
20 ning with 2017, and every two years thereafter,
21 the Secretary shall—

22 “(i) make a determination of the im-
23 proper payment rate for outpatient therapy
24 services for a 12-month period; and

1 “(ii) make such determination publicly
2 available.

3 “(B) SCALING BACK.—If the improper
4 payment rate for outpatient therapy services de-
5 termined for a 12-month period under subpara-
6 graph (A) is 50 percent or less of the Medicare
7 fee-for-service improper payment rate for such
8 period, the Secretary shall—

9 “(i) reduce the amount and extent of
10 medical review conducted for a prospective
11 year under the process established in this
12 subsection; and

13 “(ii) return an appropriate portion of
14 the funding provided for such year under
15 paragraph (11).”.

16 (2) GAO STUDY AND REPORT.—

17 (A) STUDY.—The Comptroller General of
18 the United States shall conduct a study on the
19 effectiveness of medical review of outpatient
20 therapy services under section 1833(aa) of the
21 Social Security Act, as added by paragraph (1).

22 Such study shall include an analysis of—

23 (i) aggregate data on—

1 (I) the number of individuals,
 2 therapy providers, and claims subject
 3 to such review; and

4 (II) the number of reviews con-
 5 ducted under such section; and

6 (ii) the outcomes of such reviews.

7 (B) REPORT.—Not later than 3 years after
 8 the date of enactment of this Act, the Comp-
 9 troller General shall submit to Congress a re-
 10 port containing the results of the study under
 11 subparagraph (A), together with recommenda-
 12 tions for such legislation and administrative ac-
 13 tion as the Comptroller General determines ap-
 14 propriate.

15 (c) COLLECTION OF STANDARDIZED DATA ELE-
 16 MENTS FOR OUTPATIENT THERAPY SERVICES.—

17 (1) COLLECTION OF STANDARDIZED DATA ELE-
 18 MENTS FOR OUTPATIENT THERAPY SERVICES.—Sec-
 19 tion 1834 of the Social Security Act (42 U.S.C.
 20 1395m) is amended by adding at the end the fol-
 21 lowing new subsection:

22 “(p) COLLECTION OF STANDARDIZED DATA ELE-
 23 MENTS FOR OUTPATIENT THERAPY SERVICES.—

24 “(1) STANDARDIZED DATA ELEMENTS.—

1 “(A) IN GENERAL.—Not later than 6
2 months after the date of enactment of this sub-
3 section, the Secretary shall post on the Internet
4 website of the Centers for Medicare & Medicaid
5 Services a draft list of standardized data ele-
6 ments for individuals receiving outpatient ther-
7 apy services.

8 “(B) DOMAINS.—Such standardized data
9 elements shall include information with respect
10 to the following domains, as determined appro-
11 priate by the Secretary:

12 “(i) Demographic information.

13 “(ii) Diagnosis.

14 “(iii) Severity.

15 “(iv) Affected body structures and
16 functions.

17 “(v) Limitations with activities of
18 daily living and participation.

19 “(vi) Functional status.

20 “(vii) Other domains determined to be
21 appropriate by the Secretary.

22 “(C) SOLICITATION OF INPUT.—The Sec-
23 retary shall accept comments from stakeholders
24 through the date that is 60 days after the date
25 the Secretary posts the draft list of standard-

1 ized data elements pursuant to subparagraph
2 (A). In seeking such comments, the Secretary
3 shall use one or more mechanisms to solicit
4 input from stakeholders that may include use of
5 open door forums, town hall meetings, requests
6 for information, or other mechanisms deter-
7 mined appropriate by the Secretary.

8 “(D) OPERATIONAL LIST OF STANDARD-
9 IZED DATA ELEMENTS.—Not later than 120
10 days after the end of the comment period de-
11 scribed in subparagraph (C), the Secretary, tak-
12 ing into account such comments, shall post on
13 the Internet website of the Centers for Medi-
14 care & Medicaid Services an operational list of
15 standardized data elements.

16 “(E) SUBSEQUENT REVISIONS.—Subse-
17 quent revisions to the operational list of stand-
18 ardized data elements shall be made through
19 rulemaking. Such revisions may be based on ex-
20 perience and input from stakeholders.

21 “(2) SYSTEM TO REPORT STANDARDIZED DATA
22 ELEMENTS.—

23 “(A) IN GENERAL.—Not later than 18
24 months after the date the Secretary posts the
25 operational list of standardized data elements

1 pursuant to paragraph (1)(D), the Secretary
2 shall develop and implement an electronic sys-
3 tem (which may be a web portal) for therapy
4 providers to report the standardized data ele-
5 ments for individuals with respect to outpatient
6 therapy services.

7 “(B) CONSULTATION.—The Secretary
8 shall seek comments from stakeholders regard-
9 ing the best way to report the standardized
10 data elements.

11 “(3) REPORTING.—

12 “(A) FREQUENCY OF REPORTING.—The
13 Secretary shall specify the frequency of report-
14 ing standardized data elements. The Secretary
15 shall seek comments from stakeholders regard-
16 ing the frequency of the reporting of such data
17 elements.

18 “(B) REPORTING REQUIREMENT.—Begin-
19 ning on the date the system to report standard-
20 ized data elements under this subsection is
21 operational, no payment shall be made under
22 this part for outpatient therapy services fur-
23 nished to an individual unless a therapy pro-
24 vider reports the standardized data elements for
25 such individual.

1 “(4) REPORT ON NEW PAYMENT SYSTEM FOR
2 OUTPATIENT THERAPY SERVICES.—

3 “(A) IN GENERAL.—Not later than 24
4 months after the date described in paragraph
5 (3)(B), the Secretary shall submit to Congress
6 a report on the design of a new payment system
7 for outpatient therapy services. The report shall
8 include an analysis of the standardized data ele-
9 ments collected and other appropriate data and
10 information.

11 “(B) FEATURES.—Such report shall con-
12 sider—

13 “(i) appropriate adjustments to pay-
14 ment (such as case mix and outliers);

15 “(ii) payments on an episode of care
16 basis; and

17 “(iii) reduced payment for multiple
18 episodes.

19 “(C) CONSULTATION.—The Secretary shall
20 consult with stakeholders regarding the design
21 of such a new payment system.

22 “(5) IMPLEMENTATION.—

23 “(A) FUNDING.—For purposes of imple-
24 menting this subsection, the Secretary shall
25 provide for the transfer, from the Federal Sup-

1 plementary Medical Insurance Trust Fund
2 under section 1841, of \$7,000,000 to the Cen-
3 ters for Medicare & Medicaid Services Program
4 Management Account for each of fiscal years
5 2014 through 2018. Amounts transferred under
6 this subparagraph shall remain available until
7 expended.

8 “(B) ADMINISTRATION.—Chapter 35 of
9 title 44, United States Code, shall not apply to
10 specification of the standardized data elements
11 and implementation of the system to report
12 such standardized data elements under this
13 subsection.

14 “(C) LIMITATION.—There shall be no ad-
15 ministrative or judicial review under section
16 1869, section 1878, or otherwise of the speci-
17 fication of standardized data elements required
18 under this subsection or the system to report
19 such standardized data elements.

20 “(D) DEFINITION OF OUTPATIENT THER-
21 APY SERVICES AND THERAPY PROVIDER.—In
22 this subsection, the terms ‘outpatient therapy
23 services’ and ‘therapy provider’ have the mean-
24 ing given those term in section 1833(aa).”.

1 (2) SUNSET OF CURRENT CLAIMS-BASED COL-
2 LECTION OF THERAPY DATA.—Section 3005(g)(1) of
3 the Middle Class Tax Extension and Job Creation
4 Act of 2012 (42 U.S.C. 1395l note) is amended, in
5 the first sentence, by inserting “and ending on the
6 date the system to report standardized data ele-
7 ments under section 1834(p) of the Social Security
8 Act (42 U.S.C. 1395m(p)) is implemented,” after
9 “January 1, 2013,”.

10 (d) REPORTING OF CERTAIN INFORMATION.—Sec-
11 tion 1842(t) of the Social Security Act (42 U.S.C.
12 1395u(t)) is amended by adding at the end the following
13 new paragraph:

14 “(3) Each request for payment, or bill submitted, by
15 a therapy provider (as defined in section 1833(aa)(10))
16 for an outpatient therapy service (as defined in such sec-
17 tion) furnished by a therapy assistant on or after January
18 1, 2015, shall include (in a form and manner specified
19 by the Secretary) an indication that the service was fur-
20 nished by a therapy assistant.”.

21 **SEC. 203. MEDICARE AMBULANCE SERVICES.**

22 (a) EXTENSION OF CERTAIN AMBULANCE ADD-ON
23 PAYMENTS.—

24 (1) GROUND AMBULANCE.—Section
25 1834(l)(13)(A) of the Social Security Act (42 U.S.C.

1 1395m(l)(13)(A)) is amended by striking “April 1,
2 2014” and inserting “January 1, 2019” each place
3 it appears.

4 (2) SUPER RURAL AMBULANCE.—Section
5 1834(l)(12)(A) of the Social Security Act (42 U.S.C.
6 1395m(l)(12)(A)) is amended, in the first sentence,
7 by striking “April 1, 2014” and inserting “January
8 1, 2019”.

9 (b) REQUIRING AMBULANCE PROVIDERS TO SUBMIT
10 COST AND OTHER INFORMATION.—Section 1834(l) of the
11 Social Security Act (42 U.S.C. 1395m(l)) is amended by
12 adding at the end the following new paragraph:

13 “(16) SUBMISSION OF COST AND OTHER INFOR-
14 MATION.—

15 “(A) DEVELOPMENT OF DATA COLLECTION
16 SYSTEM.—The Secretary shall develop a data
17 collection system (which may include use of a
18 cost survey and standardized definitions) for
19 providers and suppliers of ambulance services to
20 collect cost, revenue, utilization, and other in-
21 formation determined appropriate by the Sec-
22 retary. Such system shall be designed to submit
23 information—

1 “(i) needed to evaluate the appro-
2 priateness of payment rates under this
3 subsection;

4 “(ii) on the utilization of capital
5 equipment and ambulance capacity; and

6 “(iii) on different types of ambulance
7 services furnished in different geographic
8 locations, including rural areas and low
9 population density areas described in para-
10 graph (12).

11 “(B) SPECIFICATION OF DATA COLLEC-
12 TION SYSTEM.—

13 “(i) IN GENERAL.—Not later than
14 July 1, 2015, the Secretary shall—

15 “(I) specify the data collection
16 system under subparagraph (A) and
17 the time period during which such
18 data is required to be submitted; and

19 “(II) identify the providers and
20 suppliers of ambulance services who
21 would be required to submit the infor-
22 mation under such data collection sys-
23 tem.

24 “(ii) RESPONDENTS.—Subject to sub-
25 paragraph (D)(ii), the Secretary shall de-

1 termine an appropriate sample of providers
2 and suppliers of ambulance services to sub-
3 mit information under the data collection
4 system for each period for which reporting
5 of data is required.

6 “(C) PENALTY FOR FAILURE TO REPORT
7 COST AND OTHER INFORMATION.—Beginning
8 on July 1, 2016, a 5 percent reduction to pay-
9 ments under this part shall be made for a 1-
10 year prospective period specified by the Sec-
11 retary to a provider or supplier of ambulance
12 services who—

13 “(i) is identified under subparagraph
14 (B)(i)(II) as being required to submit the
15 information under the data collection sys-
16 tem; and

17 “(ii) does not submit such information
18 during the period specified under subpara-
19 graph (B)(i)(I).

20 “(D) ONGOING DATA COLLECTION.—

21 “(i) REVISION OF DATA COLLECTION
22 SYSTEM.—The Secretary may, as deter-
23 mined appropriate, periodically revise the
24 data collection system.

1 “(ii) SUBSEQUENT DATA COLLEC-
2 TION.—In order to continue to evaluate
3 the appropriateness of payment rates
4 under this subsection, the Secretary shall,
5 for years after 2016 (but not less often
6 than once every 3 years), require providers
7 and suppliers of ambulance services to sub-
8 mit information for a period the Secretary
9 determines appropriate. The penalty de-
10 scribed in subparagraph (C) shall apply to
11 such subsequent data collection periods.

12 “(E) CONSULTATION.—The Secretary shall
13 consult with stakeholders in carrying out the
14 development of the system and collection of in-
15 formation under this paragraph, including the
16 activities described in subparagraphs (A) and
17 (D). Such consultation shall include the use of
18 requests for information and other mechanisms
19 determined appropriate by the Secretary.

20 “(F) ADMINISTRATION.—Chapter 35 of
21 title 44, United States Code, shall not apply to
22 the collection of information required under this
23 subsection.

24 “(G) LIMITATIONS ON REVIEW.—There
25 shall be no administrative or judicial review

1 under section 1869, section 1878, or otherwise
 2 of the data collection system or identification of
 3 respondents under this paragraph.

4 “(H) FUNDING FOR IMPLEMENTATION.—
 5 For purposes of carrying out subparagraph (A),
 6 the Secretary shall provide for the transfer,
 7 from the Federal Supplementary Medical Insur-
 8 ance Trust Fund under section 1841, of
 9 \$1,000,000 to the Centers for Medicare & Med-
 10 icaid Services Program Management Account
 11 for fiscal year 2014. Amounts transferred under
 12 this subparagraph shall remain available until
 13 expended.”.

14 **SEC. 204. REVISION OF THE MEDICARE-DEPENDENT HOS-**
 15 **PITAL (MDH) PROGRAM.**

16 (a) PERMANENT EXTENSION OF PAYMENT METHOD-
 17 OLOGY.—

18 (1) IN GENERAL.—Section 1886(d)(5)(G) of
 19 the Social Security Act (42 U.S.C.
 20 1395ww(d)(5)(G)) is amended—

21 (A) in clause (i), by striking “and before
 22 April 1, 2014,”; and

23 (B) in clause (ii)(II), by striking “and be-
 24 fore April 1, 2014,”.

25 (2) CONFORMING AMENDMENTS.—

1 (A) TARGET AMOUNT.—Section
2 1886(b)(3)(D) of the Social Security Act (42
3 U.S.C. 1395ww(b)(3)(D)) is amended—

4 (i) in the matter preceding clause (i),
5 by striking “and before April 1, 2014,”;
6 and

7 (ii) in clause (iv), by striking
8 “through fiscal year 2013 and the portion
9 of fiscal year 2014 before April 1, 2014”
10 and inserting “or a subsequent fiscal
11 year”.

12 (B) HOSPITAL VALUE-BASED PURCHASING
13 PROGRAM.—Section 1886(o)(7)(D)(ii)(I) of the
14 Social Security Act (42 U.S.C.
15 1395ww(o)(7)(D)(ii)(I)) is amended by striking
16 “(with respect to discharges occurring during
17 fiscal year 2012 and 2013)”.

18 (C) HOSPITAL READMISSION REDUCTION
19 PROGRAM.—Section 1886(q)(2)(B)(i) of the So-
20 cial Security Act (42 U.S.C.
21 1395ww(q)(2)(B)(i)) is amended by striking
22 “(with respect to discharges occurring during
23 fiscal years 2012 and 2013)”.

24 (D) PERMITTING HOSPITALS TO DECLINE
25 RECLASSIFICATION.—Section 13501(e)(2) of

1 the Omnibus Budget Reconciliation Act of 1993
2 (42 U.S.C. 1395ww note) is amended by strik-
3 ing “fiscal year 1998, fiscal year 1999, or fiscal
4 year 2000 through the first 2 quarters of fiscal
5 year 2014” and inserting “or fiscal year 1998
6 or a subsequent fiscal year”.

7 (b) GAO STUDY AND REPORT ON MEDICARE-DE-
8 PENDENT HOSPITALS.—

9 (1) STUDY.—The Comptroller General of the
10 United States shall conduct a study on the following:

11 (A) The payor mix of medicare-dependent,
12 small rural hospitals (as defined in section
13 1886(d)(5)(G)(iv)), how such mix will trend in
14 future years, and whether or not the require-
15 ment under subclause (IV) of such section
16 should be revised.

17 (B) The characteristics of medicare-de-
18 pendent, small rural hospitals that meet the re-
19 quirement of such subclause (IV) through the
20 application of paragraph (a)(iii)(A) or
21 (a)(iii)(B) of section 412.108 of the Code of
22 Federal Regulations, including Medicare inpa-
23 tient and outpatient utilization, payor mix, and
24 financial status, including Medicare and total

1 margins, and whether or not Medicare pay-
2 ments for such hospitals should be revised.

3 (C) Such other items related to medicare-
4 dependent, small rural hospitals as the Comp-
5 troller General determines appropriate.

6 (2) REPORT.—Not later than 12 months after
7 the date of the enactment of this Act, the Comp-
8 troller General of the United States shall submit to
9 Congress a report on the study conducted under
10 paragraph (1), together with recommendations for
11 such legislation and administrative action as the
12 Comptroller General determines appropriate.

13 (c) IMPLEMENTATION.—Notwithstanding any other
14 provision of law, for purposes of fiscal year 2014, the Sec-
15 retary of Health and Human Services may implement the
16 provisions of, and the amendments made by, this section
17 through program instruction or otherwise.

18 **SEC. 205. REVISION OF MEDICARE INPATIENT HOSPITAL**
19 **PAYMENT ADJUSTMENT FOR LOW-VOLUME**
20 **HOSPITALS.**

21 (a) IN GENERAL.—Section 1886(d)(12) of the Social
22 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

23 (1) in subparagraph (B)—

1 (A) in the subparagraph heading, by in-
2 serting “FOR FISCAL YEARS 2005 THROUGH
3 2010” after “INCREASE”; and

4 (B) in the matter preceding clause (i), by
5 striking “and for discharges occurring in the
6 portion of fiscal year 2014 beginning on April
7 1, 2014, fiscal year 2015, and subsequent
8 years”;

9 (2) in subparagraph (C)(i)—

10 (A) by striking “fiscal years 2011, 2012,
11 and 2013, and the portion of fiscal year 2014
12 before” and inserting “fiscal year 2011 and
13 subsequent fiscal years,” each place it appears;
14 and

15 (B) by striking “or portion of fiscal year”
16 after “during the fiscal year”; and

17 (3) in subparagraph (D)—

18 (A) in the heading, by striking “TEM-
19 PORARY APPLICABLE PERCENTAGE INCREASE”
20 and inserting “APPLICABLE PERCENTAGE IN-
21 CREASE FOR FISCAL YEAR 2011 AND SUBSE-
22 QUENT FISCAL YEARS”;

23 (B) by striking “fiscal years 2011, 2012,
24 and 2013, and the portion of fiscal year 2014

1 before April 1, 2014” and inserting “fiscal year
2 2011 or a subsequent fiscal year”; and

3 (C) by striking “or the portion of fiscal
4 year” after “in the fiscal year”.

5 (b) IMPLEMENTATION.—Notwithstanding any other
6 provision of law, for purposes of fiscal year 2014, the Sec-
7 retary of Health and Human Services may implement the
8 provisions of, and the amendments made by, this section
9 through program instruction or otherwise.

10 **SEC. 206. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**
11 **SPECIAL NEEDS INDIVIDUALS.**

12 (a) EXTENSION.—Section 1859(f)(1) of the Social
13 Security Act (42 U.S.C. 1395w-28(f)(1)) is amended—

14 (1) by striking “ENROLLMENT.—In the case”
15 and inserting “ENROLLMENT.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graphs (B) and (C), in the case”;

18 (2) in subparagraph (A), as added by para-
19 graph (1), by striking “and for periods before Janu-
20 ary 1, 2016”; and

21 (3) by adding at the end the following new sub-
22 paragraphs:

23 “(B) APPLICATION TO DUAL SNPS.—Sub-
24 paragraph (A) shall only apply to a specialized
25 MA plan for special needs individuals described

1 in subsection (b)(6)(B)(ii) for periods before
2 January 1, 2021.

3 “(C) APPLICATION TO SEVERE OR DIS-
4 ABLING CHRONIC CONDITION SNPS.—Subpara-
5 graph (A) shall only apply to a specialized MA
6 plan for special needs individuals described in
7 subsection (b)(6)(B)(iii) for periods before Jan-
8 uary 1, 2018.”.

9 (b) INCREASED INTEGRATION OF DUAL SNPS.—

10 (1) IN GENERAL.—Section 1859(f) of the Social
11 Security Act (42 U.S.C. 1395w–28(f)) is amended—

12 (A) in paragraph (3), by adding at the end
13 the following new subparagraph:

14 “(F) The plan meets the requirements ap-
15 plicable under paragraph (8).”; and

16 (B) by adding at the end the following new
17 paragraph:

18 “(8) INCREASED INTEGRATION OF DUAL
19 SNPS.—

20 “(A) DESIGNATED CONTACT.—The Sec-
21 retary, acting through the Federal Coordinated
22 Health Care Office (Medicare-Medicaid Coordi-
23 nation Office) established under section 2602 of
24 the Patient Protection and Affordable Care Act
25 (in this paragraph referred to as the ‘MMCO’),

1 shall serve as a dedicated point of contact for
2 States to address misalignments that arise with
3 the integration of specialized MA plans for spe-
4 cial needs individuals described in subsection
5 (b)(6)(B)(ii) under this paragraph. Consistent
6 with such role, the MMCO shall—

7 “(i) establish a uniform process for
8 disseminating to State Medicaid agencies
9 information under this title impacting con-
10 tracts between such agencies and such
11 plans under this subsection; and

12 “(ii) establish basic resources for
13 States interested in exploring such plans
14 as a platform for integration.

15 “(B) UNIFIED GRIEVANCES AND APPEALS
16 PROCESS.—

17 “(i) IN GENERAL.—Not later than
18 April 1, 2015, the Secretary shall establish
19 procedures unifying the grievances and ap-
20 peals procedures under sections 1852(f),
21 1852(g), 1902(a)(3), and 1902(a)(5) for
22 items and services provided by specialized
23 MA plans for special needs individuals de-
24 scribed in subsection (b)(6)(B)(ii) under
25 this title and title XIX. The Secretary

1 shall solicit comment in developing such
2 procedures from States, plans, beneficiary
3 representatives, and other relevant stake-
4 holders.

5 “(ii) PROCEDURES.—The procedures
6 established under clause (i) shall—

7 “(I) adopt the most protective
8 provisions for the enrollee under cur-
9 rent law, including continuation of
10 benefits under title XIX pending ap-
11 peal if an appeal is filed in a timely
12 manner;

13 “(II) take into account dif-
14 ferences in State plans under title
15 XIX;

16 “(III) be easily navigable by an
17 enrollee; and

18 “(IV) include the elements de-
19 scribed in clause (iii).

20 “(iii) ELEMENTS DESCRIBED.—The
21 following elements are described in this
22 clause:

23 “(I) Single notification of all ap-
24 plicable grievances and appeal rights
25 under this title and title XIX.

1 “(II) Notices written in plain lan-
2 guage and available in a language and
3 format that is accessible to the en-
4 rollee.

5 “(III) Unified timeframes for in-
6 ternal and external grievances and ap-
7 peals processes, such as an individ-
8 ual’s filing of a grievance or appeal, a
9 plan’s acknowledgment and resolution
10 of a grievance or appeal, and notifica-
11 tion of decisions with respect to a
12 grievance or appeal.

13 “(IV) Guidelines to allow the
14 plan to process, track, and resolve
15 grievances and appeals, to ensure
16 beneficiaries are notified on a timely
17 basis of decisions that are made
18 throughout the grievance or appeals
19 process and are able to easily deter-
20 mine the status of a grievance or ap-
21 peal.

22 “(C) REQUIREMENT FOR UNIFIED GRIEV-
23 ANCES AND APPEALS.—

24 “(i) IN GENERAL.—For 2016 and
25 subsequent years, the contract of a special-

1 ized MA plan for special needs individuals
2 described in subsection (b)(6)(B)(ii) with a
3 State Medicaid agency under this sub-
4 section shall require the use of unified
5 grievances and appeals procedures as de-
6 scribed in subparagraph (B).

7 “(ii) CONSIDERATION OF APPLICA-
8 TION FOR OTHER SNPS.—The Secretary
9 shall consider applying the unified griev-
10 ances and appeals process described in
11 subparagraph (B) to specialized MA plans
12 for special needs individuals described in
13 subsection (b)(6)(B)(i) and subsection
14 (b)(6)(B)(iii) that have a substantial por-
15 tion of enrollees who are dually eligible for
16 benefits under this title and title XIX and
17 are at risk for full benefits under title
18 XIX.

19 “(D) REQUIREMENT FOR FULL INTEGRA-
20 TION FOR CERTAIN DUAL SNPS.—

21 “(i) REQUIREMENT.—Subject to the
22 succeeding provisions of this subparagraph,
23 for 2018 and subsequent years, a special-
24 ized MA plan for special needs individuals

1 described in subsection (b)(6)(B)(ii)
2 shall—

3 “(I) integrate all benefits under
4 this title and title XIX; and

5 “(II) meet the requirements of a
6 fully integrated plan described in sec-
7 tion 1853(a)(1)(B)(iv)(II) (other than
8 the requirement that the plan have
9 similar average levels of frailty, as de-
10 termined by the Secretary, as the
11 PACE program), including with re-
12 spect to long-term care services or be-
13 havioral health services to the extent
14 State law permits capitation of those
15 services under such plan.

16 “(ii) INITIAL SANCTIONS FOR FAIL-
17 URE TO MEET REQUIREMENT FOR 2018 OR
18 2019.—For each of 2018 and 2019, if the
19 Secretary determines that a plan has failed
20 to meet the requirement described in
21 clause (i), the Secretary shall impose one
22 of the following on the plan:

23 “(I) A reduction in payment to
24 the plan under this part in an amount
25 at least equal to the portion of the

1 monthly rebate computed under sec-
2 tion 1854(b)(1)(C)(i) for the plan and
3 year that would otherwise be kept by
4 the plan after application of the bene-
5 ficiary rebate rule under section
6 1854(b)(1)(C).

7 “(II) Closing enrollment in the
8 plan.

9 “(III) Sanctioning the plan in ac-
10 cordance with section 1857(g).

11 “(IV) Other reasonable action
12 (other than the sanction described in
13 clause (iii)) the Secretary determines
14 appropriate.

15 “(iii) SANCTIONS FOR FAILURE TO
16 MEET REQUIREMENT FOR 2020 AND SUBSE-
17 QUENT YEARS.—For 2020 and subsequent
18 years, if the Secretary determines that a
19 plan has failed to meet the requirement de-
20 scribed in clause (i), the plan shall be
21 deemed to no longer meet the definition of
22 a specialized MA plan for special needs in-
23 dividuals described in subsection
24 (b)(6)(B)(ii).

1 “(iv) LIMITATION.—This subpara-
2 graph shall not apply to a specialized MA
3 plan for special needs individuals described
4 in subsection (b)(6)(B)(ii) that only enrolls
5 individuals for whom the only medical as-
6 sistance to which the individuals are enti-
7 tled under the State plan is medicare cost
8 sharing described in section
9 1905(p)(3)(A)(ii).”.

10 (2) CONFORMING AMENDMENT TO RESPON-
11 SIBILITIES OF FEDERAL COORDINATED HEALTH
12 CARE OFFICE (MMCO).—Section 2602(d) of the Pa-
13 tient Protection and Affordable Care Act (42 U.S.C.
14 1315b(d)) is amended by adding at the end the fol-
15 lowing new paragraph:

16 “(6) To act as a designated contact for States
17 under subsection (f)(8)(A) of section 1859 of the So-
18 cial Security Act (42 U.S.C. 1395w–28) with respect
19 to the integration of specialized MA plans for special
20 needs individuals described in subsection
21 (b)(6)(B)(ii) of such section.”.

22 (c) IMPROVEMENTS TO SEVERE OR DISABLING
23 CHRONIC CONDITION SNPs.—Section 1859(f)(5) of the
24 Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amend-
25 ed—

1 (1) by striking “ALL SNPS.—The requirements”
2 and inserting “ALL SNPS.—

3 “(A) IN GENERAL.—Subject to subpara-
4 graph (B), the requirements”;

5 (2) by redesignating subparagraphs (A) and
6 (B) as clauses (i) and (ii), respectively, and indent-
7 ing appropriately;

8 (3) in clause (ii), as redesignated by paragraph
9 (2), by redesignating clauses (i) through (iii) as sub-
10 clauses (I) through (III), respectively, and indenting
11 appropriately; and

12 (4) by adding at the end the following new sub-
13 paragraph:

14 “(B) IMPROVEMENTS TO CARE MANAGE-
15 MENT REQUIREMENTS FOR SEVERE OR DIS-
16 ABLING CHRONIC CONDITION SNPS.—For 2016
17 and subsequent years, in the case of a special-
18 ized MA plan for special needs individuals de-
19 scribed in subsection (b)(6)(B)(iii), the require-
20 ments described in this paragraph include the
21 following:

22 “(i) The interdisciplinary team under
23 subparagraph (A)(ii)(III) includes a team
24 of providers with demonstrated expertise,
25 including training in an applicable spe-

1 cialty, in treating individuals similar to the
2 targeted population of the plan.

3 “(ii) Requirements developed by the
4 Secretary to provide face-to-face encoun-
5 ters with individuals enrolled in the plan
6 not less frequently than on an annual
7 basis.

8 “(iii) As part of the model of care
9 under clause (i) of subparagraph (A), the
10 results of the initial assessment and an-
11 nual reassessment under clause (ii)(I) of
12 such subparagraph of each individual en-
13 rolled in the plan are addressed in the indi-
14 vidual’s individualized care plan under
15 clause (ii)(II) of such subparagraph.

16 “(iv) As part of the annual evaluation
17 and approval of such model of care, the
18 Secretary shall take into account whether
19 the plan fulfilled the previous year’s goals
20 (as required under the model of care).

21 “(v) The Secretary shall establish a
22 minimum benchmark for each element of
23 the model of care of a plan. The Secretary
24 shall only approve a plan’s model of care
25 under this paragraph if each element of

1 the model of care meets the minimum
2 benchmark applicable under the preceding
3 sentence.”.

4 (d) GAO STUDY ON QUALITY IMPROVEMENT.—

5 (1) STUDY.—The Comptroller General of the
6 United States shall conduct a study on how the Sec-
7 retary of Health and Human Services could change
8 the quality measurement system under the Medicare
9 Advantage program under part C of title XVIII of
10 the Social Security Act (42 U.S.C. 1395w–21 et
11 seq.) to allow an accurate comparison of the quality
12 of care provided by specialized MA plans for special
13 needs individuals (as defined in section 1859(b)(6)
14 of such Act (42 U.S.C. 1395w–28(b)(6)), both for
15 individual plans and such plans overall, compared to
16 the quality of care delivered by the original Medicare
17 fee-for-service program under parts A and B of such
18 title and other Medicare Advantage plans under such
19 part C across similar populations.

20 (2) REPORT.—Not later than July 1, 2016, the
21 Comptroller General shall submit to Congress a re-
22 port containing the results of the study under para-
23 graph (1), together with recommendations for such
24 legislation and administrative action as the Comp-
25 troller General determines appropriate.

1 (e) CHANGES TO QUALITY RATINGS AND MEASURE-
2 MENT OF SNPS AND DETERMINATION OF FEASIBILITY
3 OF QUALITY MEASUREMENT AT THE PLAN LEVEL.—Sec-
4 tion 1853(o) of the Social Security Act (42 U.S.C. 1395w-
5 23(o)) is amended by adding at the end the following new
6 paragraphs:

7 “(6) CHANGES TO QUALITY RATINGS OF
8 SNPS.—

9 “(A) EMPHASIS ON IMPROVEMENT ACROSS
10 SNPS.—Subject to subparagraph (B), beginning
11 in plan year 2016, in the case of a specialized
12 MA plan for special needs individuals, the Sec-
13 retary shall increase the emphasis on the plan’s
14 improvement or decline in performance when
15 determining the star rating of the plan under
16 this subsection for the year as follows:

17 “(i)(I) For plan year 2016, at least
18 10 percent, but not more than 12 percent,
19 of the total star rating of the plan shall be
20 based on improvement or decline in per-
21 formance.

22 “(II) For plan year 2017 and subse-
23 quent plan years, at least 12 percent, but
24 not more than 15 percent, of the total star

1 rating of the plan shall be based on im-
2 provement or decline in performance.

3 “(ii) Improvement or decline in per-
4 formance under this subparagraph shall be
5 measured based on net change in the indi-
6 vidual star rating measures of the plan,
7 with appropriate weight given to specific
8 individual star ratings measures, such as
9 readmission rates, as determined by the
10 Secretary.

11 “(iii) The Secretary shall make an ap-
12 propriate adjustment to the improvement
13 rating of a plan under this subparagraph
14 if the plan has achieved a 4.5-star rating
15 or the highest rating possible overall or for
16 an individual measure in order to ensure
17 that the plan is not punished in cases
18 where it is not possible to improve.

19 “(B) NO APPLICATION TO CERTAIN
20 PLANS.—Subparagraph (A) shall not apply,
21 with respect to a year, to a specialized MA plan
22 for special needs individuals that has a rating
23 that is less than two-and-one-half stars.

24 “(C) QUALITY MEASUREMENT AT THE
25 PLAN LEVEL.—

1 “(i) IN GENERAL.—The Secretary
2 may require reporting for and apply under
3 this subsection quality measures at the
4 plan level for specialized MA plan for spe-
5 cial needs individuals instead of at the con-
6 tract level.

7 “(ii) CONSIDERATION.—The Secretary
8 shall take into consideration the minimum
9 number of enrollees in a specialized MA
10 plan for special needs individuals in order
11 to determine if a statistically significant or
12 valid measurement of quality at the plan
13 level is possible under clause (i).

14 “(iii) APPLICATION.—If the Secretary
15 applies quality measurement at the plan
16 level under this subparagraph—

17 “(I) such quality measurement
18 shall include Medicare Health Out-
19 comes Survey (HOS), Healthcare Ef-
20 fectiveness Data and Information Set
21 (HEDIS), and Consumer Assessment
22 of Healthcare Providers and Systems
23 (CAHPS) measures; and

24 “(II) payment and other adminis-
25 trative actions linked to quality meas-

1 urement (including the 5-star rating
2 system under this subsection) shall be
3 applied at the plan level in accordance
4 with this subparagraph.

5 “(7) DETERMINATION OF FEASIBILITY OF
6 QUALITY MEASUREMENT AT THE PLAN LEVEL.—

7 “(A) DETERMINATION OF FEASIBILITY.—
8 The Secretary shall determine the feasibility of
9 requiring reporting for and applying under this
10 subsection quality measures at the plan level for
11 all MA plans under this part.

12 “(B) CONSIDERATION OF CHANGE.—After
13 making a determination under subparagraph
14 (A), the Secretary shall consider requiring such
15 reporting and applying such quality measures
16 at the plan level as described in such subpara-
17 graph.”.

18 **SEC. 207. REASONABLE COST REIMBURSEMENT CON-**
19 **TRACTS.**

20 (a) ONE-YEAR TRANSITION AND NOTICE REGARDING
21 TRANSITION.—Section 1876(h)(5)(C) of the Social Secu-
22 rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

23 (1) in clause (ii), in the matter preceding sub-
24 clause (I), by striking “For any” and inserting
25 “Subject to clause (iv), for any”; and

1 (2) by adding at the end the following new
2 clauses:

3 “(iv) In the case of an eligible organization that is
4 offering a reasonable cost reimbursement contract that
5 may no longer be extended or renewed because of the ap-
6 plication of clause (ii), the following shall apply:

7 “(I) Notwithstanding such clause, such contract
8 may be extended or renewed for the two years subse-
9 quent to the previous year described in clause (ii).
10 The second of the two years described in the pre-
11 ceding sentence with respect to a contract is referred
12 to in this subsection as the ‘last reasonable cost re-
13 imbursement contract year for the contract’.

14 “(II) The organization may not enroll any new
15 enrollees under such contract during the last reason-
16 able cost reimbursement contract year for the con-
17 tract.

18 “(III) Not later than a date determined appro-
19 priate by the Secretary prior to the beginning of the
20 last reasonable cost reimbursement contract year for
21 the contract, the organization shall provide notice to
22 the Secretary as to whether or not the organization
23 will apply to have the contract converted over and
24 offered as a Medicare Advantage plan under part C

1 for the year following the last reasonable cost reim-
2 bursement contract year for the contract.

3 “(IV) If the organization provides the notice de-
4 scribed in subclause (III) that the contract will be
5 converted, the organization shall, not later than a
6 date determined appropriate by the Secretary, pro-
7 vide the Secretary with such information as the Sec-
8 retary determines appropriate in order to carry out
9 sections 1851(c)(4) and 1854(a)(5), including sub-
10 paragraph (C) of such section.

11 “(v) If an eligible organization that is offering a rea-
12 sonable cost reimbursement contract that is extended or
13 renewed pursuant to clause (iv) provides the notice de-
14 scribed in clause (iv)(III) that the contract will be con-
15 verted, the following provisions shall apply:

16 “(I) The deemed enrollment under section
17 1851(c)(4).

18 “(II) The special rule for quality increases
19 under 1853(o)(3)(A)(iv).”.

20 (b) DEEMED ENROLLMENT FROM REASONABLE
21 COST REIMBURSEMENT CONTRACTS CONVERTED TO
22 MEDICARE ADVANTAGE PLANS.—

23 (1) IN GENERAL.—Section 1851(c) of the So-
24 cial Security Act (42 U.S.C. 1395w–21(c)) is
25 amended—

1 (A) in paragraph (1), by striking “Such
2 elections” and inserting “Subject to paragraph
3 (4), such elections”; and

4 (B) by adding at the end the following:

5 “(4) DEEMED ENROLLMENT RELATING TO CON-
6 VERTED REASONABLE COST REIMBURSEMENT CON-
7 TRACTS.—

8 “(A) IN GENERAL.—On the first day of
9 the annual, coordinated election period under
10 subsection (e)(3) for plan years beginning on or
11 after January 1, 2017, an MA eligible indi-
12 vidual described in clause (i) or (ii) of subpara-
13 graph (B) is deemed to have elected to receive
14 benefits under this title through an applicable
15 MA plan (and shall be enrolled in such plan)
16 beginning with such plan year, if—

17 “(i) the individual is enrolled in a rea-
18 sonable cost reimbursement contract under
19 section 1876(h) in the previous plan year;

20 “(ii) such reasonable cost reimburse-
21 ment contract was extended or renewed for
22 the last reasonable cost reimbursement
23 contract year of the contract pursuant to
24 section 1876(h)(5)(C)(iv);

1 “(iii) the eligible organization that is
2 offering such reasonable cost reimburse-
3 ment contract provided the notice de-
4 scribed in subclause (III) of such section
5 that the contract was to be converted;

6 “(iv) the applicable MA plan—

7 “(I) is the plan that was con-
8 verted from the reasonable cost reim-
9 bursement contract described in
10 clause (iii);

11 “(II) is offered by the same enti-
12 ty (or an organization affiliated with
13 such entity that has a common owner-
14 ship interest of control) that entered
15 into such contract; and

16 “(III) is offered in the service
17 area where the individual resides;

18 “(v) the applicable MA plan provides
19 benefits, premiums, and access to in-net-
20 work and out-of-network providers that are
21 comparable to the benefits, premiums, and
22 access to in-network and out-of-network
23 providers under such reasonable cost reim-
24 bursement contract for the previous plan
25 year; and

1 “(vi) the applicable MA plan—

2 “(I) allows enrollees transitioning
3 from the converted reasonable cost
4 contract to such plan to maintain cur-
5 rent providers and course of treat-
6 ment at the time of enrollment for at
7 least 90 days after enrollment; and

8 “(II) during such period, pays
9 non-contracting providers for items
10 and services furnished to the enrollee
11 an amount that is not less than the
12 amount of payment applicable for
13 those items and services under the
14 original medicare fee-for-service pro-
15 gram under parts A and B.

16 “(B) MA ELIGIBLE INDIVIDUALS DE-
17 SCRIBED.—

18 “(i) WITHOUT PRESCRIPTION DRUG
19 COVERAGE.—An MA eligible individual de-
20 scribed in this clause, with respect to a
21 plan year, is an MA eligible individual who
22 is enrolled in a reasonable cost reimburse-
23 ment contract under section 1876(h) in the
24 previous plan year and who does not, for
25 such previous plan year, receive any pre-

1 scription drug coverage under part D, in-
2 cluding coverage under section 1860D–22.

3 “(ii) WITH PRESCRIPTION DRUG COV-
4 ERAGE.—An MA eligible individual de-
5 scribed in this clause, with respect to a
6 plan year, is an MA eligible individual who
7 is enrolled in a reasonable cost reimburse-
8 ment contract under section 1876(h) in the
9 previous plan year and who, for such pre-
10 vious plan year, receives prescription drug
11 coverage under part D—

12 “(I) through such contract; or

13 “(II) through a prescription drug
14 plan, if the sponsor of such plan is the
15 same entity (or an organization affili-
16 ated with such entity) that entered
17 into such contract.

18 “(C) APPLICABLE MA PLAN DEFINED.—In
19 this paragraph, the term ‘applicable MA plan’
20 means, in the case of an individual described
21 in—

22 “(i) subparagraph (B)(i), an MA plan
23 that is not an MA–PD plan; and

24 “(ii) subparagraph (B)(ii), an MA–
25 PD plan.

1 “(D) IDENTIFICATION AND NOTIFICATION
2 OF DEEMED INDIVIDUALS.—Not later than 30
3 days before the first day of the annual, coordi-
4 nated election period under subsection (e)(3)
5 for plan years beginning on or after January 1,
6 2017, the Secretary shall identify and notify the
7 individuals who will be subject to deemed elec-
8 tions under subparagraph (A) on the first day
9 of such period.”.

10 (2) BENEFICIARY OPTION TO DISCONTINUE OR
11 CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED
12 ENROLLMENT.—

13 (A) IN GENERAL.—Section 1851(e)(2) of
14 the Social Security Act (42 U.S.C. 1395w–
15 21(e)(4)) is amended by adding at the end the
16 following:

17 “(F) SPECIAL PERIOD FOR CERTAIN
18 DEEMED ELECTIONS.—

19 “(i) IN GENERAL.—At any time dur-
20 ing the period beginning after the last day
21 of the annual, coordinated election period
22 under paragraph (3) in which an individual
23 is deemed to have elected to enroll in an
24 MA plan or MA–PD plan under subsection
25 (c)(4) and ending on the last day of Feb-

1 ruary of the first plan year for which the
2 individual is enrolled in such plan, such in-
3 dividual may change the election under
4 subsection (a)(1) (including changing the
5 MA plan or MA–PD plan in which the in-
6 dividual is enrolled).

7 “(ii) LIMITATION OF ONE CHANGE.—
8 An individual may exercise the right under
9 clause (i) only once during the applicable
10 period described in such clause. The limita-
11 tion under this clause shall not apply to
12 changes in elections effected during an an-
13 nual, coordinated election period under
14 paragraph (3) or during a special enroll-
15 ment period under paragraph (4).”.

16 (B) CONFORMING AMENDMENTS.—

17 (i) PLAN REQUIREMENT FOR OPEN
18 ENROLLMENT.—Section 1851(e)(6)(A) of
19 the Social Security Act (42 U.S.C. 1395w-
20 21(e)(6)(A)) is amended by striking “para-
21 graph (1),” and inserting “paragraph (1),
22 during the period described in paragraph
23 (2)(F),”.

1 (ii) PART D.—Section 1860D–
 2 1(b)(1)(B) of such Act (42 U.S.C. 1395w–
 3 101(b)(1)(B)) is amended—

4 (I) in clause (ii), by adding “and
 5 paragraph (4)” after “paragraph
 6 (3)(A)”; and

7 (II) in clause (iii) by striking
 8 “and (E)” and inserting “(E), and
 9 (F)”.

10 (3) TREATMENT OF ESRD FOR DEEMED EN-
 11 ROLLMENT.—Section 1851(a)(3)(B) of the Social
 12 Security Act (42 U.S.C. 1395w–21(a)(3)(B)) is
 13 amended by adding at the end the following flush
 14 sentence:

15 “An individual who develops end-stage renal
 16 disease while enrolled in a reasonable cost reim-
 17 bursement contract under section 1876(h) shall
 18 be treated as an MA eligible individual for pur-
 19 poses of applying the deemed enrollment under
 20 subsection (c)(4).”.

21 (c) INFORMATION REQUIREMENTS.—Section
 22 1851(d)(2)(B) of the Social Security Act (42 U.S.C.
 23 1395w–21(d)(2)(B)) is amended—

24 (1) by striking the subparagraph heading and
 25 inserting the following: “(i) NOTIFICATION TO

1 NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE
2 INDIVIDUALS.—”; and

3 (2) by adding at the end the following:

4 “(ii) NOTIFICATION RELATED TO CERTAIN
5 DEEMED ELECTIONS.—The Secretary shall re-
6 quire the converting cost plan to mail, not later
7 than 15 days prior to the first day of the an-
8 nual, coordinated election period under sub-
9 section (e)(3) of a year, to any individual iden-
10 tified by the Secretary under subsection
11 (e)(4)(D) for such year—

12 “(I) a notification that such individual
13 will, on such day, be deemed to have made
14 an election to receive benefits under this
15 title through an MA plan or MA–PD plan
16 (and shall be enrolled in such plan) for the
17 next plan year under subsection (e)(4)(A),
18 but that the individual may make a dif-
19 ferent election during the annual, coordi-
20 nated election period for such year;

21 “(II) the information described in
22 subparagraph (A);

23 “(III) a description of the differences
24 between such MA plan or MA–PD plan
25 and the reasonable cost reimbursement

1 contract in which the individual was most
2 recently enrolled with respect to benefits
3 covered under such plans, including cost-
4 sharing, premiums, drug coverage, and
5 provider networks;

6 “(IV) information about the special
7 period for elections under subsection
8 (e)(2)(F); and

9 “(V) other information the Secretary
10 may specify”.

11 (d) TREATMENT OF TRANSITION PLAN FOR QUALITY
12 RATING FOR PAYMENT PURPOSES.—Section 1853(o)(4)
13 of the Social Security Act (42 U.S.C. 1395w-23(o)(4)) is
14 amended by adding at the end the following new subpara-
15 graph:

16 “(C) SPECIAL RULE FOR FIRST 3 PLAN
17 YEARS FOR PLANS THAT WERE CONVERTED
18 FROM A REASONABLE COST REIMBURSEMENT
19 CONTRACT.—For purposes of applying para-
20 graph (1) and section 1854(b)(1)(C) for the
21 first 3 plan years under this part in the case of
22 an MA plan to which deemed enrollment applies
23 under section 1851(c)(4)—

1 “(i) such plan shall not be treated as
 2 a new plan (as defined in paragraph
 3 (3)(A)(iii)(II)); and

4 “(ii) in determining the star rating of
 5 the plan under subparagraph (A), to the
 6 extent that Medicare Advantage data for
 7 such plan is not available for a measure
 8 used to determine such star rating, the
 9 Secretary shall use data from the period in
 10 which such plan was a reasonable cost re-
 11 imbursement contract.”.

12 **SEC. 208. QUALITY MEASURE ENDORSEMENT AND SELEC-**
 13 **TION.**

14 (a) CONTRACT WITH AN ENTITY REGARDING INPUT
 15 ON THE SELECTION OF MEASURES.—

16 (1) IN GENERAL.—Title XVIII of the Social Se-
 17 curity Act (42 U.S.C. 1395 et seq.) is amended—

18 (A) by redesignating section 1890A as sec-
 19 tion 1890B; and

20 (B) by inserting after section 1890 the fol-
 21 lowing new section:

22 “CONTRACT WITH AN ENTITY REGARDING INPUT ON THE
 23 SELECTION OF MEASURES

24 “SEC. 1890A (a) CONTRACT.—

25 “(1) IN GENERAL.—For purposes of activities
 26 conducted under this Act, the Secretary shall iden-

1 tify and have in effect a contract with an entity that
2 meets the requirements described in subsection (c).
3 Such contract shall provide that the entity will per-
4 form the duties described in subsection (b).

5 “(2) TIMING FOR FIRST CONTRACT.—The first
6 contract under paragraph (1) shall begin on, or as
7 soon as practicable after, October 1, 2014.

8 “(3) PERIOD OF CONTRACT.—A contract under
9 paragraph (1) shall be for a period of 3 years (ex-
10 cept as may be renewed after a subsequent bidding
11 process).

12 “(4) COMPETITIVE PROCEDURES.—Competitive
13 procedures (as defined in section 4(5) of the Office
14 of Federal Procurement Policy Act (41 U.S.C.
15 403(5))) shall be used to enter into a contract under
16 paragraph (1).

17 “(b) DUTIES.—The duties described in this sub-
18 section are the following:

19 “(c) REQUIREMENTS DESCRIBED.—The require-
20 ments described in this subsection are the following:

21 “(1) PRIVATE NONPROFIT, BOARD MEMBER-
22 SHIP, MEMBERSHIP FEES, AND NOT A MEASURE DE-
23 VELOPER.—The requirements described in para-
24 graphs (1), (2), (7), and (8) of section 1890(c).

1 “(2) EXPERIENCE.—The entity has at least 4
2 years of experience working with quality and effi-
3 ciency measures.”.

4 (2) DUTIES OF ENTITY.—

5 (A) TRANSFER OF PRIORITY SETTING
6 PROCESS.—Paragraph (1) of section 1890(b) of
7 the Social Security Act (42 U.S.C. 1395aaa(b))
8 is redesignated as paragraph (1) of section
9 1890A(b) of such Act, as added by paragraph
10 (1).

11 (B) TRANSFER OF MULTI-STAKEHOLDER
12 PROCESS.—Paragraphs (7) and (8) of such sec-
13 tion 1890(b) are redesignated as paragraphs
14 (2) and (3), respectively, of section 1890A(b) of
15 such Act, as added by paragraph (1) and
16 amended by subparagraph (A).

17 (C) ADDITIONAL DUTIES.—Section
18 1890A(b) of such Act, as added by paragraph
19 (1) and amended by subparagraphs (A) and
20 (B), is amended by adding at the end the fol-
21 lowing new paragraphs:

22 “(4) FACILITATION TO BETTER COORDINATE
23 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF
24 QUALITY MEASURES.—

1 “(A) IN GENERAL.—The entity shall facili-
2 tate increased coordination and alignment be-
3 tween the public and private sector with respect
4 to quality and efficiency measures.

5 “(B) REPORTS.—The entity shall prepare
6 and make available to the public annual reports
7 on its findings under this paragraph. Such pub-
8 lic availability shall include posting each report
9 on the Internet website of the entity.

10 “(5) GAP ANALYSIS.—The entity shall conduct
11 an ongoing analysis of—

12 “(A) gaps in endorsed quality and effi-
13 ciency measures, which shall include measures
14 that are within priority areas identified by the
15 Secretary under the national strategy estab-
16 lished under section 399HH of the Public
17 Health Service Act; and

18 “(B) areas where quality measures are un-
19 available or inadequate to identify or address
20 such gaps.

21 “(6) ANNUAL REPORT TO CONGRESS AND THE
22 SECRETARY; SECRETARIAL PUBLICATION AND COM-
23 MENT.—

24 “(A) ANNUAL REPORT.—By not later than
25 June 1 of each year, the entity shall submit to

1 Congress and the Secretary a report con-
2 taining—

3 “(i) a description of—

4 “(I) the recommendations made
5 under paragraph (1);

6 “(II) the matters described in
7 clauses (i) and (ii) of paragraph
8 (2)(A);

9 “(III) the results of the analysis
10 under paragraph (5); and

11 “(IV) the performance by the en-
12 tity of the duties required under the
13 contract entered into with the Sec-
14 retary under subsection (a); and

15 “(ii) any other items determined ap-
16 propriate by the Secretary.

17 “(B) SECRETARIAL REVIEW AND PUBLICA-
18 TION OF ANNUAL REPORT.—Not later than 6
19 months after receiving a report under subpara-
20 graph (A), the Secretary shall—

21 “(i) review such report; and

22 “(ii) publish such report in the Fed-
23 eral Register, together with any comments
24 of the Secretary on such report.”.

1 (D) ADDITIONAL AMENDMENTS.—Section
2 1890A(b) of such Act, as so added and amend-
3 ed, is amended—

4 (i) in paragraph (2)—

5 (I) in subparagraph (A)(i)—

6 (aa) in subclause (I), by in-
7 serting “with a contract under
8 section 1890” after “entity”; and

9 (bb) in subclause (II), by
10 striking “such entity” and insert-
11 ing “the entity with a contract
12 under section 1890”;

13 (II) in the heading of subpara-
14 graph (B) by inserting “AND EFFI-
15 CIENCY” after “QUALITY”;

16 (III) in subparagraph (B)(i)(III),
17 by striking “this Act” and inserting
18 “this title”; and

19 (IV) by adding at the end the fol-
20 lowing new subparagraphs:

21 “(E) INPUT.—In providing the input de-
22 scribed in subparagraph (A), the multi-stake-
23 holder groups—

24 “(i) shall include a detailed descrip-
25 tion of the rationale for each recommenda-

1 tion made by the multi-stakeholder group,
2 including in areas relating to—

3 “(I) the expected impact that im-
4 plementing the measure will have on
5 individuals;

6 “(II) the burden on providers of
7 services and suppliers;

8 “(III) the expected influence over
9 the behavior of providers of services
10 and suppliers;

11 “(IV) the applicability of a meas-
12 ure for more than one setting or pro-
13 gram; and

14 “(V) other areas determined in
15 consultation with the Secretary; and

16 “(ii) may consider whether it is appro-
17 priate to provide separate recommenda-
18 tions with respect to measures for internal
19 use, public reporting, and payment provi-
20 sions.

21 “(F) EQUAL REPRESENTATION.—In con-
22 vening multi-stakeholder groups pursuant to
23 this paragraph, the entity shall, to the extent
24 feasible, make every effort to ensure such
25 groups are balanced across stakeholders.”; and

1 (ii) in paragraph (3), by striking “Not
2 later” and all that follows through the pe-
3 riod at the end and inserting the following:
4 “Not later than the applicable dates de-
5 scribed in section 1890B(a)(3) of each
6 year (or, as applicable, the timeframe de-
7 scribed in section 1890B(a)(4)), the entity
8 shall transmit to the Secretary the input of
9 the multi-stakeholder groups under para-
10 graph (2).”.

11 (b) REVISIONS TO CONTRACT WITH CONSENSUS-
12 BASED ENTITY.—

13 (1) CONTRACT.—Section 1890(a) of the Social
14 Security Act (42 U.S.C. 1395aaa(a)) is amended—

15 (A) in paragraph (1), by striking “, such
16 as the National Quality Forum,”; and

17 (B) in paragraph (3), by striking “4
18 years” and inserting “3 years”.

19 (2) DUTIES.—Section 1890(b) of the Social Se-
20 curity Act (42 U.S.C. 1395aaa(b)), as amended by
21 subsection (a)(2), is amended—

22 (A) by redesignating paragraphs (2) and
23 (3) as paragraphs (1) and (2), respectively;

1 (B) in paragraph (2), as redesignated by
2 subparagraph (A), by striking “paragraph (2)”
3 and inserting “paragraph (1)”;

4 (C) by striking paragraphs (5) and (6);
5 and

6 (D) by adding at the end the following new
7 paragraphs:

8 “(3) FACILITATION TO BETTER COORDINATE
9 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF
10 QUALITY MEASURES.—

11 “(A) IN GENERAL.—The entity shall facili-
12 tate increased coordination and alignment be-
13 tween the public and private sector with respect
14 to quality and efficiency measures.

15 “(B) REPORTS.—The entity shall prepare
16 and make available to the public annual reports
17 on its findings under this paragraph. Such pub-
18 lic availability shall include posting each report
19 on the Internet website of the entity.

20 “(4) ANNUAL REPORT TO CONGRESS AND THE
21 SECRETARY; SECRETARIAL PUBLICATION AND COM-
22 MENT.—

23 “(A) ANNUAL REPORT.—By not later than
24 March 1 of each year, the entity shall submit

1 to Congress and the Secretary a report con-
2 taining—

3 “(i) a description of—

4 “(I) the coordination of quality
5 initiatives under this title and titles
6 XIX and XXI with quality initiatives
7 implemented by other payers;

8 “(II) areas in which evidence is
9 insufficient to support endorsement of
10 quality measures in priority areas
11 identified by the Secretary under the
12 national strategy established under
13 section 399HH of the Public Health
14 Service Act and where targeted re-
15 search may address such gaps; and

16 “(III) the performance by the en-
17 tity of the duties required under the
18 contract entered into with the Sec-
19 retary under subsection (a); and

20 “(ii) any other items determined ap-
21 propriate by the Secretary.

22 “(B) SECRETARIAL REVIEW AND PUBLICA-
23 TION OF ANNUAL REPORT.—Not later than 6
24 months after receiving a report under subpara-
25 graph (A), the Secretary shall—

1 “(i) review such report; and

2 “(ii) publish such report in the Fed-
3 eral Register, together with any comments
4 of the Secretary on such report.”.

5 (3) REQUIREMENTS.—Section 1890(c) of the
6 Social Security Act (42 U.S.C. 1395aaa(c)) is
7 amended by adding at the end the following new
8 paragraph:

9 “(8) NOT A MEASURE DEVELOPER.—The entity
10 is not a measure developer.”.

11 (c) REVISIONS TO DUTIES OF THE SECRETARY RE-
12 GARDING USE OF MEASURES.—

13 (1) IN GENERAL.—Section 1890B(a) of the So-
14 cial Security Act (42 U.S.C. 1395aaa–1(a)), as re-
15 designated by subsection (a)(1)(A), is amended—

16 (A) by striking “section 1890(b)(7)(B)”
17 each place it appears and inserting “section
18 1890A(b)(2)(B)”;

19 (B) in paragraph (1)—

20 (i) by striking “section 1890(b)(7)”
21 and inserting “section 1890A(b)(2)”;

22 (ii) by striking “section 1890” and in-
23 serting “section 1890A”;

24 (C) by striking paragraphs (2) and (3) and
25 inserting the following:

1 “(2) PUBLIC AVAILABILITY OF MEASURES CON-
2 SIDERED FOR SELECTION.—Subject to paragraph
3 (4), not later than October 1 or December 31 of
4 each year (or as soon as practicable after such dates
5 for the first year of the contract), the Secretary
6 shall make available to the public a list of quality
7 and efficiency measures described in section
8 1890A(b)(2)(B) that the Secretary is considering
9 under this title. The Secretary shall provide for an
10 appropriate balance of the number of measures to be
11 made available by each such date in a year.

12 “(3) TRANSMISSION OF MULTI-STAKEHOLDER
13 INPUT.—

14 “(A) IN GENERAL.—Subject to paragraph
15 (4), not later than the applicable date described
16 in subparagraph (B) of each year, the entity
17 with a contract under section 1890A shall, pur-
18 suant to subsection (b)(3) of such section,
19 transmit to the Secretary the input of multi-
20 stakeholder groups described in paragraph (1).

21 “(B) APPLICABLE DATE DESCRIBED.—The
22 applicable date described in this subparagraph
23 for a year is—

24 “(i) February 1 (or as soon as prac-
25 ticable after such date for the first year of

1 the contract) with respect to quality and
2 efficiency measures made available under
3 paragraph (2) by October 1 of the pre-
4 ceding year; and

5 “(ii) April 1 (or as soon as practicable
6 after such dates for the first year of the
7 contract) with respect to quality and effi-
8 ciency measures made available under
9 paragraph (2) by December 31 of the pre-
10 ceding year.”;

11 (D) by redesignating—

12 (i) paragraph (6) as paragraph (8);

13 and

14 (ii) paragraphs (4) and (5) as para-
15 graphs (5) and (6), respectively;

16 (E) by inserting after paragraph (3) the
17 following new paragraph:

18 “(4) LIMITED PROCESS FOR ADDITIONAL
19 MULTI-STAKEHOLDER INPUT.—In addition to the
20 Secretary making measures publically available pur-
21 suant to the dates described in paragraph (2) and
22 multi-stakeholder groups transmitting the input pur-
23 suant to the applicable dates described in paragraph
24 (3)—

1 “(A) the Secretary may, at times that do
2 not meet the time requirements described in
3 paragraph (2), make available to the public a
4 limited number of quality and efficiency meas-
5 ures described in section 1890A(b)(2) that the
6 Secretary is considering under this title; and

7 “(B) if the Secretary uses the authority
8 under subparagraph (A), the entity with a con-
9 tract under section 1890A shall, pursuant to
10 section 1890A(b)(3), transmit to the Secretary
11 on a timely basis the input from a multi-stake-
12 holder group described in paragraph (1) with
13 respect to such measures.”;

14 (F) in paragraph (6), as redesignated by
15 subparagraph (D)(ii), by inserting “or that has
16 not been recommended by the multi-stakeholder
17 group under section 1890A(b)(2)” before the
18 period at the end; and

19 (G) by inserting after paragraph (6) the
20 following new paragraph:

21 “(7) CONCORDANCE RATES.—For each year
22 (beginning with 2015), the Secretary shall include a
23 list of concordance rates with respect to the input
24 provided under section 1890A(b)(2)(A) for those
25 new measures adopted for each type of provider of

1 services and supplier in the annual final rule appli-
2 cable to such type of provider or supplier.”.

3 (2) REVIEW.—Section 1890B(c) of the Social
4 Security Act (42 U.S.C. 1395aaa–1(c)), as redesignig-
5 nated by subsection (a)(1)(A), is amended—

6 (A) in paragraph (1)(A), by striking “sec-
7 tion 1890(b)(7)(B)” and inserting “section
8 1890A(b)(2)(B)”;

9 (B) in paragraph (2)—

10 (i) in subparagraph (A), by striking
11 “and” at the end;

12 (ii) in subparagraph (B), by striking
13 the period at the end and inserting “;
14 and”;

15 (iii) by adding at the end the fol-
16 lowing new subparagraph:

17 “(C) take into consideration the benefits of
18 the alignment of measures between the public
19 and private sector.”.

20 (d) FUNDING FOR QUALITY MEASURE ENDORSE-
21 MENT, INPUT, AND SELECTION.—

22 (1) FISCAL YEAR 2014.—In addition to amounts
23 transferred under section 3014(c) of the Patient
24 Protection and Affordable Care Act (Public Law
25 111–148), for purposes of carrying out section 1890

1 and section 1890A (other than subsections (e) and
2 (f)), the Secretary shall provide for the transfer,
3 from the Federal Hospital Insurance Trust Fund
4 under section 1817 and the Federal Supplementary
5 Medical Insurance Trust Fund under section 1841,
6 in such proportion as the Secretary determines ap-
7 propriate, to the Centers for Medicare & Medicaid
8 Services Program Management Account of
9 \$7,000,000 for fiscal year 2014. Amounts trans-
10 ferred under the preceding sentence shall remain
11 available until expended.

12 (2) FISCAL YEARS 2015 THROUGH 2017.—Sec-
13 tion 1890B of the Social Security Act (42 U.S.C.
14 1395aaa-1), as redesignated by subsection
15 (a)(1)(A), is amended by adding at the end the fol-
16 lowing new subsection:

17 “(g) FUNDING.—

18 “(1) IN GENERAL.—For purposes of carrying
19 out this section (other than subsections (e) and (f))
20 and sections 1890 and 1890A, the Secretary shall
21 provide for the transfer, from the Federal Hospital
22 Insurance Trust Fund under section 1817 and the
23 Federal Supplementary Medical Insurance Trust
24 Fund under section 1841, in such proportion as the
25 Secretary determines appropriate, to the Centers for

1 Medicare & Medicaid Services Program Management
2 Account of \$25,000,000 for each of fiscal years
3 2015 through 2017.

4 “(2) AVAILABILITY.—Amounts transferred
5 under paragraph (1) shall remain available until ex-
6 pended.”.

7 (3) CONFORMING AMENDMENT.—Subsection (d)
8 of section 1890 of the Social Security Act (42
9 U.S.C. 1395aaa) is repealed.

10 (e) CONFORMING AMENDMENTS.—(1) Section
11 1848(m)(3)(E)(iii) of the Social Security Act (42 U.S.C.
12 1395w-4(m)(3)(E)(iii)) is amended by striking “section
13 1890(b)(7) and 1890A(a)” and inserting “section
14 1890A(b)(2) and 1890B(a)”.

15 (2) Section 1866D(b)(2)(C) of the Social Security
16 Act (42 U.S.C. 1395cc-4(b)(2)(C)) is amended by striking
17 “section 1890 and 1890A” and inserting “sections 1890,
18 1890A, and 1890B”.

19 (3) Section 1899A(n)(2)(A) of the Social Security
20 Act (42 U.S.C. 1395cc-4(n)(2)(A)) is amended by strik-
21 ing “section 1890(b)(7)(B)” and inserting “section
22 1890A(b)(2)(B)”.

23 (f) EFFECTIVE DATE.—

24 (1) IN GENERAL.—The amendments made by
25 this section shall take effect on October 1, 2014,

1 and shall apply with respect to contract periods
2 under sections 1890 and 1890A of the Social Secu-
3 rity Act that begin on or after such date.

4 (2) NEW CONTRACTS.—The Secretary of
5 Health and Human Services shall enter into a new
6 contract under both sections 1890 and 1890A of the
7 Social Security Act, as amended by this Act, for a
8 contract period beginning on, or as soon as prac-
9 ticable after, October 1, 2014.

10 **SEC. 209. PERMANENT EXTENSION OF FUNDING OUTREACH**
11 **AND ASSISTANCE FOR LOW-INCOME PRO-**
12 **GRAMS.**

13 (a) ADDITIONAL FUNDING FOR STATE HEALTH IN-
14 SURANCE PROGRAMS.—Subsection (a)(1)(B)(iv) of section
15 119 of the Medicare Improvements for Patients and Pro-
16 viders Act of 2008 (42 U.S.C. 1395b–3 note), as amended
17 by section 3306 of the Patient Protection and Affordable
18 Care Act (Public Law 111–148), section 610 of the Amer-
19 ican Taxpayer Relief Act of 2012 (Public Law 112–240),
20 and section 1110 of the Pathway for SGR Reform Act
21 of 2013 (Public Law 113–67), is amended to read as fol-
22 lows:

23 “(iv) for fiscal year 2014 and for each
24 subsequent fiscal year, \$7,500,000.”.

1 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON
2 AGING.—Subsection (b)(1)(B)(iv) of such section 119, as
3 so amended, is amended to read as follows:

4 “(iv) for fiscal year 2014 and for each
5 subsequent fiscal year, \$7,500,000.”.

6 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
7 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B)(iv)
8 of such section 119, as so amended, is amended to read
9 as follows:

10 “(iv) for fiscal year 2014 and for each
11 subsequent fiscal year, \$5,000,000.”.

12 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
13 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
14 ENROLLMENT.—Subsection (d)(2)(iv) of such section 119,
15 as so amended, is amended to read as follows:

16 “(iv) for fiscal year 2014 and for each
17 subsequent fiscal year, \$5,000,000.”.

18 **Subtitle B—Medicaid and Other**
19 **Extensions**

20 **SEC. 211. QUALIFYING INDIVIDUAL PROGRAM.**

21 (a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the
22 Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is
23 amended by striking “March 2104” and inserting “De-
24 cember 2018”.

1 (b) ELIMINATING LIMITATIONS ON ELIGIBILITY.—
2 Section 1933 of the Social Security Act (42 U.S.C.
3 1396u–3) is amended by striking subsections (b) and (e).

4 (c) ELIMINATING ALLOCATIONS.—Section 1933 of
5 the Social Security Act (42 U.S.C. 1396u–3) is amended
6 by striking subsections (c) and (g).

7 (d) CONFORMING AMENDMENTS.—

8 (1) IN GENERAL.—Section 1933 of the Social
9 Security Act (42 U.S.C. 1396u–3), as amended by
10 subsections (b) and (c), is further amended—

11 (A) by striking subsection (a) and insert-
12 ing the following new subsection:

13 “(a) APPLICABLE FMAP.—With respect to assist-
14 ance described in section 1902(a)(10)(E)(iv) furnished in
15 a State, the Federal medical assistance percentage shall
16 be equal to 100 percent.”;

17 (B) by striking subsection (d); and

18 (C) by redesignating subsection (f) as sub-
19 section (b).

20 (2) DEFINITION OF FMAP.—Section 1905(b) of
21 the Social Security Act (42 U.S.C. 1396d(b)) is
22 amended by striking “section 1933(d)” and insert-
23 ing “section 1933(a)”.

24 (e) EFFECTIVE DATE.—The amendments made by
25 this section shall take effect on April 1, 2014, and shall

1 apply with respect to calendar quarters beginning on or
2 after such date.

3 **SEC. 212. TRANSITIONAL MEDICAL ASSISTANCE.**

4 (a) EXTENSION.—Sections 1902(e)(1)(B) and
5 1925(f) of the Social Security Act (42 U.S.C.
6 1396a(e)(1)(B), 1396r–6(f)) are each amended by strik-
7 ing “March 31, 2014” and inserting “December 31,
8 2018”.

9 (b) OPT-OUT OPTION FOR STATES THAT EXPAND
10 ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS
11 ELIGIBILITY UNDER MEDICAID AND CHIP.—

12 (1) IN GENERAL.—Section 1925 of the Social
13 Security Act (42 U.S.C. 1396r–6), as amended by
14 subsection (a), is further amended—

15 (A) in subsection (a)—

16 (i) in paragraph (1)(A), by striking
17 “paragraph (5)” and inserting “para-
18 graphs (5) and (6)”; and

19 (ii) by adding at the end the fol-
20 lowing:

21 “(6) OPT-OUT OPTION FOR STATES THAT EX-
22 PAND ADULT COVERAGE AND PROVIDE 12-MONTH
23 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND
24 CHIP.—

1 “(A) IN GENERAL.—In the case of a State
2 described in subparagraph (B), the State may
3 elect through a State plan amendment to have
4 this section and sections 408(a)(11)(A),
5 1902(a)(52), 1902(e)(1), and 1931(c)(2) not
6 apply to the State.

7 “(B) STATE DESCRIBED.—A State is de-
8 scribed in this subparagraph if the State is one
9 of the 50 States or the District of Columbia
10 and—

11 “(i) has elected to provide medical as-
12 sistance to individuals under subclause
13 (VIII) of section 1902(a)(10)(A)(i);

14 “(ii) has elected under section
15 1902(e)(12)(A) the option to provide con-
16 tinuous eligibility for a 12-month period
17 for individuals under 19 years of age;

18 “(iii) has elected under section
19 1902(e)(12)(B) the option to provide con-
20 tinuous eligibility for a 12-month period
21 for all categories of individuals described in
22 that section; and

23 “(iv) has elected to apply section
24 1902(e)(12)(A) to the State child health
25 plan under title XXI.”; and

1 (B) in subsection (b)(1), by striking “sub-
2 section (a)(5)” and inserting “paragraphs (5)
3 and (6) of subsection (a)”.

4 (2) CONFORMING AMENDMENT TO 4-MONTH RE-
5 QUIREMENT.—Section 1902(e)(1) of the Social Se-
6 curity Act (42 U.S.C. 1396a(e)(1)), as amended by
7 subsection (a), is further amended—

8 (A) in subparagraph (B), by striking
9 “Subparagraph (A)” and inserting “Subject to
10 subparagraph (C), subparagraph (A)”; and

11 (B) by adding at the end the following:

12 “(C) If a State has made an election under section
13 1925(a)(6), subparagraph (A) and section 1925 shall not
14 apply to the State.”.

15 (c) EXTENSION OF 12-MONTH CONTINUOUS ELIGI-
16 BILITY OPTION TO CERTAIN ADULT ENROLLEES UNDER
17 MEDICAID; CLARIFICATION OF APPLICATION TO CHIP.—

18 (1) IN GENERAL.—Section 1902(e)(12) of the
19 Social Security Act (42 U.S.C. 1396a(e)(12)) is
20 amended—

21 (A) by redesignating subparagraphs (A)
22 and (B) as clauses (i) and (ii), respectively;

23 (B) by inserting “(A)” after “(12)”; and

24 (C) by adding at the end the following:

1 “(B) At the option of the State, the plan may provide
2 that an individual who is determined to be eligible for ben-
3 efits under a State plan approved under this title under
4 any of the following eligibility categories, or who is rede-
5 termined to be eligible for such benefits under any of such
6 categories, shall be considered to meet the eligibility re-
7 quirements met on the date of application and shall re-
8 main eligible for those benefits until the end of the 12-
9 month period following the date of the determination or
10 redetermination of eligibility:

11 “(i) Section 1902(a)(10)(A)(i)(VIII).

12 “(ii) Section 1931.”.

13 (2) APPLICATION TO CHIP.—Section 2107(e)(1)
14 of the Social Security Act (42 U.S.C. 1397gg(e)(1))
15 is amended—

16 (A) by redesignating subparagraphs (E)
17 through (O) as subparagraphs (F) through (P),
18 respectively; and

19 (B) by inserting after subparagraph (D),
20 the following:

21 “(E) Section 1902(e)(12)(A) (relating to
22 the State option for 12-month continuous eligi-
23 bility and enrollment).”.

1 (d) CONFORMING AND TECHNICAL AMENDMENTS
2 RELATING TO SECTION 1931 TRANSITIONAL COVERAGE
3 REQUIREMENTS.—

4 (1) IN GENERAL.—Section 1931(c) of the So-
5 cial Security Act (42 U.S.C. 1396u–1(c)) is amend-
6 ed—

7 (A) in paragraph (1)—

8 (i) in the paragraph heading, by strik-
9 ing “CHILD” and inserting “SPOUSAL”;

10 (ii) by striking “The provisions” and
11 inserting “Subject to paragraph (3), the
12 provisions”; and

13 (iii) by striking “child or”;

14 (B) in paragraph (2), by striking “For
15 continued” and inserting “Subject to paragraph
16 (3), for continued”; and

17 (C) by adding at the end the following:

18 “(3) OPT-OUT OPTION FOR STATES THAT EX-
19 PAND ADULT COVERAGE AND PROVIDE 12-MONTH
20 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND
21 CHIP.—

22 “(A) IN GENERAL.—In the case of a State
23 described in subparagraph (B), the State may
24 elect through a State plan amendment to have
25 paragraphs (1) and (2) of this subsection and

1 sections 408(a)(11), 1902(a)(52), 1902(e)(1),
2 and 1925 not apply to the State.

3 “(B) STATE DESCRIBED.—A State is de-
4 scribed in this subparagraph if the State is one
5 of the 50 States or the District of Columbia
6 and—

7 “(i) has elected to provide medical as-
8 sistance to individuals under subclause
9 (VIII) of section 1902(a)(10)(A)(i);

10 “(ii) has elected under section
11 1902(e)(12)(A) the option to provide con-
12 tinuous eligibility for a 12-month period
13 for individuals under 19 years of age;

14 “(iii) has elected under section
15 1902(e)(12)(B) the option to provide con-
16 tinuous eligibility for a 12-month period
17 for all categories of individuals described in
18 that section; and

19 “(iv) has elected to apply section
20 1902(e)(12)(A) to the State child health
21 plan under title XXI.”.

22 (2) CONFORMING AMENDMENT TO SECTION
23 408.—Section 408(a)(11) of the Social Security Act
24 (42 U.S.C. 608(a)(11) is amended—

1 (A) in the paragraph heading, by striking
2 “CHILD” and inserting “SPOUSAL”; and

3 (B) in subparagraph (B)—

4 (i) in the subparagraph heading, by
5 striking “CHILD” and inserting “SPOUS-
6 AL”; and

7 (ii) by striking “child or”.

8 (e) CONFORMING AMENDMENT RELATING TO MAIN-
9 TENANCE OF EFFORT FOR CHILDREN.—Section
10 1902(gg)(4) of the Social Security Act (42 U.S.C.
11 1396a(gg)(4)) is amended by adding at the end the fol-
12 lowing:

13 “(C) STATES THAT EXPAND ADULT COV-
14 ERAGE AND ELECT TO OPT-OUT OF TRANSI-
15 TIONAL COVERAGE.—

16 “(i) IN GENERAL.—For purposes of
17 determining compliance with the require-
18 ments of paragraph (2), a State which ex-
19 ercises the option under sections
20 1925(a)(6) and 1931(e)(3) to provide no
21 transitional medical assistance or other ex-
22 tended eligibility (as applicable) shall not,
23 as a result of exercising such option, be
24 considered to have in effect eligibility
25 standards, methodologies, or procedures

1 described in clause (ii) that are more re-
2 strictive than the standards, methodolo-
3 gies, or procedures in effect under the
4 State plan or under a waiver of the plan
5 on the date of enactment of the Patient
6 Protection and Affordable Care Act.

7 “(ii) STANDARDS, METHODOLOGIES,
8 OR PROCEDURES DESCRIBED.—The eligi-
9 bility standards, methodologies, or proce-
10 dures described in this clause are those
11 standards, methodologies, or procedures
12 applicable to determining the eligibility for
13 medical assistance of any child under 19
14 years of age (or such higher age as the
15 State may have elected).”.

16 (f) EFFECTIVE DATE.—The amendments made by
17 this section shall take effect on April 1, 2014.

18 **SEC. 213. EXPRESS LANE ELIGIBILITY.**

19 Section 1902(e)(13)(I) of the Social Security Act (42
20 U.S.C. 1396a(e)(13)(I)) is amended by striking “Sep-
21 tember 30, 2014” and inserting “September 30, 2015”.

22 **SEC. 214. PEDIATRIC QUALITY MEASURES.**

23 (a) CONTINUATION OF FUNDING FOR PEDIATRIC
24 QUALITY MEASURES FOR IMPROVING THE QUALITY OF
25 CHILDREN’S HEALTH CARE.—Section 1139B(e) of the

1 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended
2 by adding at the end the following: “Of the funds appro-
3 priated under this subsection, not less than \$15,000,000
4 shall be used to carry out section 1139A(b).”.

5 (b) **ELIMINATION OF RESTRICTION ON MEDICAID**
6 **QUALITY MEASUREMENT PROGRAM.**—Section
7 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.
8 1320b–9b(b)(5)(A)) is amended by striking “The aggre-
9 gate amount awarded by the Secretary for grants and con-
10 tracts for the development, testing, and validation of
11 emerging and innovative evidence-based measures under
12 such program shall equal the aggregate amount awarded
13 by the Secretary for grants under section
14 1139A(b)(4)(A)”.

15 **SEC. 215. SPECIAL DIABETES PROGRAMS.**

16 (a) **SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-**
17 **BETES.**—Section 330B(b)(2)(C) of the Public Health
18 Service Act (42 U.S.C. 254e–2(b)(2)(C)) is amended by
19 striking “2014” and inserting “2019”.

20 (b) **SPECIAL DIABETES PROGRAMS FOR INDIANS.**—
21 Section 330C(c)(2)(C) of the Public Health Service Act
22 (42 U.S.C. 254e–3(c)(2)(C)) is amended by striking
23 “2014” and inserting “2019”.

1 **Subtitle C—Human Services**
2 **Extensions**

3 **SEC. 221. ABSTINENCE EDUCATION GRANTS.**

4 (a) IN GENERAL.—Section 510 of the Social Security
5 Act (42 U.S.C. 710) is amended—

6 (1) in subsection (a), in the matter preceding
7 paragraph (1), by striking “2010 through 2014”
8 and inserting “2015 through 2019”; and

9 (2) in subsection (d)—

10 (A) by striking “2010 through 2014” and
11 inserting “2015 through 2019”; and

12 (B) by striking the second sentence.

13 (b) EFFECTIVE DATE.—The amendments made by
14 this section shall take effect on October 1, 2014.

15 **SEC. 222. PERSONAL RESPONSIBILITY EDUCATION PRO-**
16 **GRAM.**

17 (a) IN GENERAL.—Section 513 of the Social Security
18 Act (42 U.S.C. 713) is amended—

19 (1) in subsection (a)—

20 (A) in paragraph (1)(A), by striking “2010
21 through 2014” and inserting “2015 through
22 2019”;

23 (B) in paragraph (4)—

24 (i) in subparagraph (A)—

1 (I) by striking “2010 or 2011”
2 and inserting “2015 or 2016”;

3 (II) by striking “2010 through
4 2014” and inserting “2015 through
5 2019”; and

6 (III) by striking “2012 through
7 2014” and inserting “2017 through
8 2019”; and

9 (ii) in subparagraph (B)(i)—

10 (I) by striking “2012, 2013, and
11 2014” and inserting “2017, 2018,
12 and 2019”; and

13 (II) by striking “2010 or 2011”
14 and inserting “2015 or 2016”; and

15 (C) in paragraph (5), by striking “2009”
16 and inserting “2014”;

17 (2) in subsection (b)(2)(A), in the matter pre-
18 ceding clause (i), by inserting “and youth at risk of
19 becoming victims of sex trafficking (as defined in
20 section 103(10) of the Trafficking Victims Protec-
21 tion Act of 2000 (22 U.S.C. 7102(10))) or victims
22 of a severe form of trafficking in persons described
23 in paragraph (9)(A) of that Act (22 U.S.C.
24 7102(9)(A))” after “adolescents”;

1 (3) in subsection(c)(1), by inserting “youth at
2 risk of becoming victims of sex trafficking (as de-
3 fined in section 103(10) of the Trafficking Victims
4 Protection Act of 2000 (22 U.S.C. 7102(10))) or
5 victims of a severe form of trafficking in persons de-
6 scribed in paragraph (9)(A) of that Act (22 U.S.C.
7 7102(9)(A),” after “youth in foster care,”; and

8 (4) in subsection (f), by striking “2010 through
9 2014” and inserting “2015 through 2019”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect on October 1, 2014.

12 **SEC. 223. FAMILY-TO-FAMILY HEALTH INFORMATION CEN-**
13 **TERS.**

14 (a) IN GENERAL.—Section 501(c) of the Social Secu-
15 rity Act (42 U.S.C. 701(c)) is amended—

16 (1) in paragraph (1)(A), by striking clause (iv)
17 and inserting the following:

18 “(iv) \$6,000,000 for each of fiscal
19 years 2014 through 2018.”; and

20 (2) by striking paragraph (5).

21 (b) PREVENTION OF DUPLICATE APPROPRIATIONS
22 FOR FISCAL YEAR 2014.—Expenditures made for fiscal
23 year 2014 pursuant to section 501(c)(iv) of the Social Se-
24 curity Act (42 U.S.C. 701(c)(iv)), as amended by section
25 1203 of division B of the Bipartisan Budget Act of 2013

1 (Public Law 113–67), shall be charged to the appropria-
 2 tion for that fiscal year provided by the amendments made
 3 by this section.

4 **SEC. 224. HEALTH WORKFORCE DEMONSTRATION PROJECT**
 5 **FOR LOW-INCOME INDIVIDUALS.**

6 Section 2008(c)(1) of the Social Security Act (42
 7 U.S.C. 1397g(c)(1)) is amended by striking “ through
 8 2014” and inserting “2012, and only to carry out sub-
 9 section (a), \$85,000,000 for each of fiscal years 2013
 10 through 2016”.

11 **TITLE III—MEDICARE AND**
 12 **MEDICAID PROGRAM INTEGRITY**

13 **SEC. 301. REDUCING IMPROPER MEDICARE PAYMENTS.**

14 (a) **MEDICARE ADMINISTRATIVE CONTRACTOR IM-**
 15 **PROPER PAYMENT OUTREACH AND EDUCATION PRO-**
 16 **GRAM.—**

17 (1) **IN GENERAL.—**Section 1874A of the Social
 18 Security Act (42 U.S.C. 1395kk–1) is amended—

19 (A) in subsection (a)(4)—

20 (i) by redesignating subparagraph (G)
 21 as subparagraph (H); and

22 (ii) by inserting after subparagraph
 23 (F) the following new subparagraph:

24 “(G) **IMPROPER PAYMENT OUTREACH AND**
 25 **EDUCATION PROGRAM.—**Having in place an im-

1 proper payment outreach and education pro-
2 gram described in subsection (h).”; and

3 (B) by adding at the end the following new
4 subsection:

5 “(h) IMPROPER PAYMENT OUTREACH AND EDU-
6 CATION PROGRAM.—

7 “(1) IN GENERAL.—In order to reduce im-
8 proper payments under this title, each medicare ad-
9 ministrative contractor shall establish and have in
10 place an improper payment outreach and education
11 program under which the contractor, through out-
12 reach, education, training, and technical assistance
13 activities, shall provide providers of services and sup-
14 pliers located in the region covered by the contract
15 under this section with the information described in
16 paragraph (3). The activities described in the pre-
17 ceding sentence shall be conducted on a regular
18 basis.

19 “(2) FORMS OF OUTREACH, EDUCATION, TRAIN-
20 ING, AND TECHNICAL ASSISTANCE ACTIVITIES.—The
21 outreach, education, training, and technical assist-
22 ance activities under a payment outreach and edu-
23 cation program shall be carried out through any of
24 the following:

1 “(A) Emails and other electronic commu-
2 nications.

3 “(B) Webinars.

4 “(C) Telephone calls.

5 “(D) In-person training.

6 “(E) Other forms of communications de-
7 termined appropriate by the Secretary.

8 “(3) INFORMATION TO BE PROVIDED THROUGH
9 ACTIVITIES.—The information to be provided to pro-
10 viders of services and suppliers under a payment
11 outreach and education program shall include all of
12 the following information:

13 “(A) A list of the provider’s or supplier’s
14 most frequent and expensive payment errors
15 over the last quarter.

16 “(B) Specific instructions regarding how to
17 correct or avoid such errors in the future.

18 “(C) A notice of all new topics that have
19 been approved by the Secretary for audits con-
20 ducted by recovery audit contractors under sec-
21 tion 1893(h).

22 “(D) Specific instructions to prevent fu-
23 ture issues related to such new audits.

24 “(E) Other information determined appro-
25 priate by the Secretary.

1 “(4) ERROR RATE REDUCTION TRAINING.—

2 “(A) IN GENERAL.—The activities under a
3 payment outreach and education program shall
4 include error rate reduction training.

5 “(B) REQUIREMENTS.—

6 “(i) IN GENERAL.—The training de-
7 scribed in subparagraph (A) shall—

8 “(I) be provided at least annu-
9 ally; and

10 “(II) focus on reducing the im-
11 proper payments described in para-
12 graph (5).

13 “(C) INVITATION.—A medicare adminis-
14 trative contractor shall ensure that all providers
15 of services and suppliers located in the region
16 covered by the contract under this section are
17 invited to attend the training described in sub-
18 paragraph (A) either in person or online.

19 “(5) PRIORITY.—A medicare administrative
20 contractor shall give priority to activities under the
21 improper payment outreach and education program
22 that will reduce improper payments for items and
23 services that—

24 “(A) have the highest rate of improper
25 payment;

1 “(B) have the greatest total dollar amount
2 of improper payments;

3 “(C) are due to clear misapplication or
4 misinterpretation of Medicare policies;

5 “(D) are clearly due to common and inad-
6 vertent clerical or administrative errors; or

7 “(E) are due to other types of errors that
8 the Secretary determines could be prevented
9 through activities under the program.

10 “(6) INFORMATION ON IMPROPER PAYMENTS
11 FROM RECOVERY AUDIT CONTRACTORS.—

12 “(A) IN GENERAL.—In order to assist
13 medicare administrative contractors in carrying
14 out improper payment outreach and education
15 programs, the Secretary shall provide each con-
16 tractor with a complete list of improper pay-
17 ments identified by recovery audit contractors
18 under section 1893(h) with respect to providers
19 of services and suppliers located in the region
20 covered by the contract under this section. Such
21 information shall be provided on a quarterly
22 basis.

23 “(B) INFORMATION.—The information de-
24 scribed in subparagraph (A) shall include the
25 following information:

1 “(i) The providers of services and
2 suppliers that have the highest rate of im-
3 proper payments.

4 “(ii) The providers of services and
5 suppliers that have the greatest total dollar
6 amounts of improper payments.

7 “(iii) The items and services furnished
8 in the region that have the highest rates of
9 improper payments.

10 “(iv) The items and services furnished
11 in the region that are responsible for the
12 greatest total dollar amount of improper
13 payments.

14 “(v) Other information the Secretary
15 determines would assist the contractor in
16 carrying out the improper payment out-
17 reach and education program.

18 “(C) FORMAT OF INFORMATION.—The in-
19 formation furnished to medicare administrative
20 contractors by the Secretary under this para-
21 graph shall be transmitted in a manner that
22 permits the contractor to easily identify the
23 areas of the Medicare program in which tar-
24 geted outreach, education, training, and tech-
25 nical assistance would be most effective. In car-

1 rying out the preceding sentence, the Secretary
2 shall ensure that—

3 “(i) the information with respect to
4 improper payments made to a provider of
5 services or supplier clearly displays the
6 name and address of the provider or sup-
7 plier, the amount of the improper payment,
8 and any other information the Secretary
9 determines appropriate; and

10 “(ii) the information is in an elec-
11 tronic, easily searchable database.

12 “(7) COMMUNICATIONS.—All communications
13 with providers of services and suppliers under a pay-
14 ment outreach and education program are subject to
15 the standards and requirements of subsection (g).

16 “(8) FUNDING.—After application of paragraph
17 (1)(C) of section 1893(h), the Secretary shall retain
18 a portion of the amounts recovered by recovery audit
19 contractors under such section which shall be avail-
20 able to the program management account of the
21 Centers for Medicare & Medicaid Services for pur-
22 poses of carrying out this subsection and to imple-
23 ment corrective actions to help reduce the error rate
24 of payments under this title. The amount retained
25 under the preceding sentence shall not exceed an

1 amount equal to 25 percent of the amounts recov-
2 ered under section 1893(h).”.

3 (2) FUNDING CONFORMING AMENDMENT.—Sec-
4 tion 1893(h)(2) of the Social Security Act (42
5 U.S.C. 1395ddd(h)(2)) is amended by inserting “or
6 section 1874(h)(8)” after “paragraph (1)(C)”.

7 (3) EFFECTIVE DATE.—The amendments made
8 by this subsection take effect on January 1, 2015.

9 (b) TRANSPARENCY.—Section 1893(h)(8) of the So-
10 cial Security Act (42 U.S.C. 1395ddd(h)(8)) is amended—

11 (1) by striking “REPORT.—The Secretary” and
12 inserting “REPORT.—

13 “(A) IN GENERAL.—The Secretary”; and

14 (2) by adding at the end the following new sub-
15 paragraph:

16 “(B) INCLUSION OF CERTAIN INFORMA-
17 TION.—

18 “(i) IN GENERAL.—For reports sub-
19 mitted under this paragraph for 2015 or a
20 subsequent year, each such report shall in-
21 clude the information described in clause
22 (ii) with respect to each of the following
23 categories of audits carried out by recovery
24 audit contractors under this subsection:

25 “(I) Automated.

1 “(II) Complex.

2 “(III) Medical necessity review.

3 “(IV) Part A.

4 “(V) Part B.

5 “(VI) Durable medical equip-
6 ment.

7 “(ii) INFORMATION DESCRIBED.—For
8 purposes of clause (i), the information de-
9 scribed in this clause, with respect to a
10 category of audit described in clause (i), is
11 the result of all appeals for each individual
12 level of appeals in such category.”.

13 (c) RECOVERY AUDIT CONTRACTOR DEMONSTRA-
14 TION PROJECT.—

15 (1) IN GENERAL.—The Secretary shall conduct
16 a demonstration project under title XVIII of the So-
17 cial Security Act that—

18 (A) targets audits by recovery audit con-
19 tractors under section 1893(h) of the Social Se-
20 curity Act (42 U.S.C. 1395ddd(h)) with respect
21 to high error providers of services and suppliers
22 identified under paragraph (3); and

23 (B) rewards low error providers of services
24 and suppliers identified under such paragraph.

25 (2) SCOPE.—

1 (A) DURATION.—The demonstration
2 project shall be implemented not later than
3 January 1, 2015, and shall be conducted for a
4 period of three years.

5 (B) DEMONSTRATION AREA.—In deter-
6 mining the geographic area of the demonstra-
7 tion project, the Secretary shall consider the
8 following:

9 (i) The total number of providers of
10 services and suppliers in the region.

11 (ii) The diversity of types of providers
12 of services and suppliers in the region.

13 (iii) The level and variation of im-
14 proper payment rates of and among indi-
15 vidual providers of services and suppliers
16 in the region.

17 (iv) The inclusion of a mix of both
18 urban and rural areas.

19 (3) IDENTIFICATION OF LOW ERROR AND HIGH
20 ERROR PROVIDERS OF SERVICES AND SUPPLIERS.—

21 (A) IN GENERAL.—In conducting the dem-
22 onstration project, the Secretary shall identify
23 the following two groups of providers in accord-
24 ance with this paragraph:

1 (i) Low error providers of services and
2 suppliers.

3 (ii) High error providers of services
4 and suppliers.

5 (B) ANALYSIS.—For purposes of identi-
6 fying the groups under subparagraph (A), the
7 Secretary shall analyze the following as they re-
8 late to the total number and amount of claims
9 submitted in the area and by each provider:

10 (i) The improper payment rates of in-
11 dividual providers of services and suppliers.

12 (ii) The amount of improper payments
13 made to individual providers of services
14 and suppliers.

15 (iii) The frequency of errors made by
16 the provider of services or supplier over
17 time.

18 (iv) Other information determined ap-
19 propriate by the Secretary.

20 (C) ASSIGNMENT BASED ON COMPOSITE
21 SCORE.—The Secretary shall assign selected
22 providers of services and suppliers under the
23 demonstration program based on a composite
24 score determined using the analysis under sub-
25 paragraph (B) as follows:

1 (i) Providers of services and suppliers
2 with high, expensive, and frequent errors
3 shall receive a high score and be identified
4 as high error providers of services and sup-
5 pliers under subparagraph (A).

6 (ii) Providers of services and suppliers
7 with few, inexpensive, and infrequent er-
8 rors shall receive a low score and be identi-
9 fied as low error providers of services and
10 suppliers under such subparagraph.

11 (iii) Only a small proportion of the
12 total providers of services and suppliers
13 and individual types of providers of serv-
14 ices and suppliers in the geographic area
15 of the demonstration project shall be as-
16 signed to either group identified under
17 such subparagraph.

18 (D) TIMEFRAME OF IDENTIFICATION.—

19 (i) IN GENERAL.—Any identification
20 of a provider of services or a supplier
21 under subparagraph (A) shall be for a pe-
22 riod of 12 months.

23 (ii) REEVALUATION.—The Secretary
24 shall reevaluate each such identification at
25 the end of such period.

1 (iii) USE OF MOST CURRENT INFOR-
2 MATION.—In carrying out the reevaluation
3 under clause (ii) with respect to a provider
4 of services or supplier, the Secretary
5 shall—

6 (I) consider the most current in-
7 formation available with respect to the
8 provider of services or supplier under
9 the analysis under subparagraph (B);
10 and

11 (II) take into account improve-
12 ment or regression of the provider of
13 services or supplier.

14 (4) ADJUSTMENT OF RECORD REQUEST MAX-
15 IMUM.—Under the demonstration project, the Sec-
16 retary shall establish procedures to—

17 (A) increase the maximum record request
18 made by recovery audit contractors to providers
19 of services and suppliers identified as high error
20 providers of services and suppliers under para-
21 graph (3); and

22 (B) decrease the maximum record request
23 made by recovery audit contractors to providers
24 of services and suppliers identified as low error

1 providers of services and supplier under such
2 paragraph.

3 (5) ADDITIONAL ADJUSTMENTS.—

4 (A) IN GENERAL.—Under the demonstra-
5 tion project, the Secretary may make additional
6 adjustments to requirements for recovery audit
7 contractors under section 1893(h) of the Social
8 Security Act (42 U.S.C. 1395ddd(h)) and the
9 conduct of audits with respect to low error pro-
10 viders of services and suppliers identified under
11 paragraph (3) and high error providers of serv-
12 ices and suppliers identified under such para-
13 graph as the Secretary determines necessary in
14 order to incentivize reductions in improper pay-
15 ment rates under title XVIII of such Act (42
16 U.S.C. 1395 et seq.).

17 (B) LIMITATION.—The Secretary shall not
18 exempt any group of providers of services or
19 suppliers in the demonstration project from
20 being subject to audit by a recovery audit con-
21 tractor under such section 1893(h).

22 (6) EVALUATION AND REPORT.—

23 (A) EVALUATION.—The Inspector General
24 of the Department of Health and Human Serv-
25 ices shall conduct an evaluation of the dem-

1 demonstration project under this subsection. The
2 evaluation shall include an analysis of—

3 (i) the error rates of providers of serv-
4 ices and suppliers—

5 (I) identified under paragraph
6 (3) as low error providers of services
7 and suppliers;

8 (II) identified under such para-
9 graph as high error providers of serv-
10 ices and suppliers; and

11 (III) that are located in the geo-
12 graphic area of the demonstration
13 project and are not identified as either
14 a low error or high error provider of
15 services or supplier under such para-
16 graph; and

17 (ii) any improvements in the error
18 rates of those high error providers of serv-
19 ices and suppliers identified under such
20 paragraph.

21 (B) REPORT.—Not later than 12 months
22 after completion of the demonstration project,
23 the Inspector General shall submit to Congress
24 a report containing the results of the evaluation
25 conducted under subparagraph (A), together

1 with recommendations on whether the dem-
2 onstration project should be continued or ex-
3 panded, including on a permanent or nation-
4 wide basis.

5 (7) FUNDING.—

6 (A) FUNDING FOR IMPLEMENTATION.—

7 For purposes of carrying out the demonstration
8 project under this subsection (other than the
9 evaluation and report under paragraph (6)), the
10 Secretary shall provide for the transfer, from
11 the Federal Hospital Insurance Trust Fund
12 under section 1817 (42 U.S.C. 1395i) and the
13 Federal Supplementary Medical Insurance
14 Trust Fund under section 1841 (42 U.S.C.
15 1395t), in such proportion as the Secretary de-
16 termines appropriate, of \$10,000,000 to the
17 Centers for Medicare & Medicaid Services Pro-
18 gram Management Account.

19 (B) FUNDING FOR INSPECTOR GENERAL

20 EVALUATION AND REPORT.—For purposes of
21 carrying out the evaluation and report under
22 paragraph (6), the Secretary shall provide for
23 the transfer, from the Federal Hospital Insur-
24 ance Trust Fund under such section 1817 and
25 the Federal Supplementary Medical Insurance

1 Trust Fund under such section 1841, in such
2 proportion as the Secretary determines appro-
3 priate, of \$245,000 to the Inspector General of
4 the Department of Health and Human Services.

5 (C) AVAILABILITY.—Amounts transferred
6 under subparagraph (A) or (B) shall remain
7 available until expended.

8 (8) DEFINITIONS.—In this section:

9 (A) DEMONSTRATION PROJECT.—The term
10 “demonstration project” means the demonstra-
11 tion project under this subsection.

12 (B) PROVIDER OF SERVICES.—The term
13 “provider of services” has the meaning given
14 that term in section 1861(u).

15 (C) RECOVERY AUDIT CONTRACTOR.—The
16 term “recovery audit contractor” means an en-
17 tity with a contract under section 1893(h) of
18 the Social Security Act (42 U.S.C.
19 1395ddd(h)).

20 (D) SECRETARY.—The term “Secretary”
21 means the Secretary of Health and Human
22 Services.

23 (E) SUPPLIER.—The term “supplier” has
24 the meaning given that term in section 1861(d).

1 **SEC. 302. AUTHORITY FOR MEDICAID FRAUD CONTROL**
2 **UNITS TO INVESTIGATE AND PROSECUTE**
3 **COMPLAINTS OF ABUSE AND NEGLECT OF**
4 **MEDICAID PATIENTS IN HOME AND COMMU-**
5 **NITY-BASED SETTINGS.**

6 (a) IN GENERAL.—Section 1903(q)(4)(A) of the So-
7 cial Security Act (42 U.S.C. 1396b(q)(4)(A)) is amended
8 to read as follows:

9 “(4)(A) The entity’s function includes a state-
10 wide program for the—

11 “(i) investigation and prosecution, or refer-
12 ral for prosecution or other action, of com-
13 plaints of abuse or neglect of patients in health
14 care facilities which receive payments under the
15 State plan under this title or under a waiver of
16 such plan;

17 “(ii) at the option of the entity, investiga-
18 tion and prosecution, or referral for prosecution
19 or other action, of complaints of abuse or ne-
20 glect of individuals in connection with any as-
21 pect of the provision of medical assistance and
22 the activities of providers of such assistance in
23 a home or community based setting that is paid
24 for under the State plan under this title or
25 under a waiver of such plan; and

1 “(iii) at the option of the entity, investiga-
2 tion and prosecution, or referral for prosecution
3 or other action, of complaints of abuse or ne-
4 glect of patients residing in board and care fa-
5 cilities.”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall take effect on January 1, 2015.

8 **SEC. 303. IMPROVED USE OF FUNDS RECEIVED BY THE HHS**
9 **INSPECTOR GENERAL FROM OVERSIGHT AND**
10 **INVESTIGATIVE ACTIVITIES.**

11 (a) IN GENERAL.—Section 1128C(b) of the Social
12 Security Act (42 U.S.C. 1320a–7c(b)) is amended to read
13 as follows:

14 “(b) ADDITIONAL USE OF FUNDS BY INSPECTOR
15 GENERAL.—

16 “(1) COLLECTIONS FROM MEDICARE AND MED-
17 ICAID RECOVERY ACTIONS.—Notwithstanding section
18 3302 of title 31, United States Code, or any other
19 provision of law affecting the crediting of collections,
20 the Inspector General of the Department of Health
21 and Human Services may receive and retain for cur-
22 rent use three percent of all amounts collected pur-
23 suant to civil debt collection and administrative en-
24 forcement actions related to false claims or frauds

1 involving the Medicare program under title XVIII or
 2 the Medicaid program under title XIX.

3 “(2) CREDITING.—Funds received by the In-
 4 spector General under paragraph (1) shall be depos-
 5 ited as offsetting collections to the credit of any ap-
 6 propriation available for oversight and enforcement
 7 activities of the Inspector General permitted under
 8 subsection (a), and shall remain available until ex-
 9 pended.”.

10 (b) EFFECTIVE DATE.—The amendment made by
 11 subsection (a) shall apply to funds received from settle-
 12 ments finalized, judgments entered, or final agency deci-
 13 sions issued, on or after the date of the enactment of this
 14 Act.

15 **SEC. 304. PREVENTING AND REDUCING IMPROPER MEDI-**
 16 **CARE AND MEDICAID EXPENDITURES.**

17 (a) REQUIRING VALID PRESCRIBER NATIONAL PRO-
 18 VIDER IDENTIFIERS ON PHARMACY CLAIMS.—Section
 19 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–
 20 104(c)) is amended by adding at the end the following new
 21 paragraph:

22 “(4) REQUIRING VALID PRESCRIBER NATIONAL
 23 PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

24 “(A) IN GENERAL.—For plan year 2015
 25 and subsequent plan years, subject to subpara-

1 graph (B), the Secretary shall prohibit PDP
2 sponsors of prescription drug plans from paying
3 claims for prescription drugs under this part
4 that do not include a valid prescriber National
5 Provider Identifier.

6 “(B) PROCEDURES.—The Secretary shall
7 establish procedures for determining the validity
8 of prescriber National Provider Identifiers
9 under subparagraph (A).

10 “(C) REPORT.—Not later than January 1,
11 2017, the Inspector General of the Department
12 of Health and Human Services shall submit to
13 Congress a report on the effectiveness of the
14 procedures established under subparagraph
15 (B).”.

16 (b) REFORMING HOW CMS TRACKS AND CORRECTS
17 THE VULNERABILITIES IDENTIFIED BY RECOVERY AUDIT
18 CONTRACTORS.—Section 1893(h) of the Social Security
19 Act (42 U.S.C. 1395ddd(h)) is amended—

20 (1) in paragraph (8), as amended by section
21 301, by adding at the end the following new sub-
22 paragraphs:

23 “(C) INCLUSION OF IMPROPER PAYMENT
24 VULNERABILITIES IDENTIFIED.—For reports
25 submitted under this paragraph for 2015 or a

1 subsequent year, each such report shall in-
2 clude—

3 “(i) a description of—

4 “(I) the types and financial cost
5 to the program under this title of im-
6 proper payment vulnerabilities identi-
7 fied by recovery audit contractors
8 under this subsection; and

9 “(II) how the Secretary is ad-
10 dressing such improper payment
11 vulnerabilities; and

12 “(ii) an assessment of the effective-
13 ness of changes made to payment policies
14 and procedures under this title in order to
15 address the vulnerabilities so identified.

16 “(D) LIMITATION.—The Secretary shall
17 ensure that each report submitted under sub-
18 paragraph (A) does not include information
19 that the Secretary determines would be sen-
20 sitive or would otherwise negatively impact pro-
21 gram integrity.”; and

22 (2) by adding at the end the following new
23 paragraph:

24 “(10) ADDRESSING IMPROPER PAYMENT
25 VULNERABILITIES.—The Secretary shall address im-

1 proper payment vulnerabilities identified by recovery
2 audit contractors under this subsection in a timely
3 manner, prioritized based on the risk to the program
4 under this title.”.

5 (c) STRENGTHENING MEDICAID PROGRAM INTEG-
6 RITY THROUGH FLEXIBILITY.—Section 1936 of the Social
7 Security Act (42 U.S.C. 1396u–6) is amended—

8 (1) in subsection (a), by inserting “, or other-
9 wise,” after “entities”; and

10 (2) in subsection (e)—

11 (A) in paragraph (1), in the matter pre-
12 ceding subparagraph (A), by inserting “(includ-
13 ing the costs of equipment, salaries and bene-
14 fits, and travel and training)” after “Program
15 under this section”; and

16 (B) in paragraph (3), by striking “by 100”
17 and inserting “by 100, or such number as de-
18 termined necessary by the Secretary to carry
19 out the Program under this section,”.

20 (d) ACCESS TO THE NATIONAL DIRECTORY OF NEW
21 HIRES.—Section 453(j) of the Social Security Act (42
22 U.S.C. 653(j)) is amended by adding at the end the fol-
23 lowing new paragraph:

24 “(12) INFORMATION COMPARISONS AND DIS-
25 CLOSURES TO ASSIST IN ADMINISTRATION OF THE

1 MEDICARE PROGRAM AND STATE HEALTH SUBSIDY
2 PROGRAMS.—

3 “(A) DISCLOSURE TO THE ADMINIS-
4 TRATOR OF THE CENTERS FOR MEDICARE &
5 MEDICAID SERVICES.—The Administrator of
6 the Centers for Medicare & Medicaid shall have
7 access to the information in the National Direc-
8 tory of New Hires for purposes of determining
9 the eligibility of an applicant for, or enrollee in,
10 the Medicare program under title XVIII or an
11 applicable State health subsidy program (as de-
12 fined in section 1413(e) of the Patient Protec-
13 tion and Affordable Care Act (42 U.S.C.
14 18083(e)).

15 “(B) DISCLOSURE TO THE INSPECTOR
16 GENERAL OF THE DEPARTMENT OF HEALTH
17 AND HUMAN SERVICES.—

18 “(i) IN GENERAL.—If the Inspector
19 General of the Department of Health and
20 Human Services transmits to the Secretary
21 the names and social security account
22 numbers of individuals, the Secretary shall
23 disclose to the Inspector General informa-
24 tion on such individuals and their employ-

1 ers maintained in the National Directory
2 of New Hires.

3 “(ii) USE OF INFORMATION.—The In-
4 specter General of the Department of
5 Health and Human Services may use in-
6 formation provided under clause (i) only
7 for purposes of —

8 “(I) enforcing mandatory and
9 permissive exclusions under title XI;
10 or

11 “(II) evaluating the integrity of
12 the Medicare program or an applica-
13 ble State health subsidy program (as
14 defined in section 1413(e) of the Pa-
15 tient Protection and Affordable Care
16 Act).

17 The authority under this clause is in addi-
18 tion to any authority conferred under the
19 Inspector General Act of 1978 (5 U.S.C.
20 App).

21 “(C) DISCLOSURE TO STATE AGENCIES.—

22 “(i) IN GENERAL.—If, for purposes of
23 determining the eligibility of an applicant
24 for, or an enrollee in, an applicable State
25 health subsidy program (as defined in sec-

1 tion 1413(e) of the Patient Protection and
2 Affordable Care Act (42 U.S.C. 18083(e)),
3 a State agency responsible for admin-
4 istering such program transmits to the
5 Secretary the names, dates of birth, and
6 social security account numbers of individ-
7 uals, the Secretary shall disclose to such
8 State agency information on such individ-
9 uals and their employers maintained in the
10 National Directory of New Hires, subject
11 to this subparagraph.

12 “(ii) CONDITION ON DISCLOSURE BY
13 THE SECRETARY.—The Secretary shall
14 make a disclosure under clause (i) only to
15 the extent that the Secretary determines
16 that the disclosure would not interfere with
17 the effective operation of the program
18 under this part.

19 “(iii) USE AND DISCLOSURE OF IN-
20 FORMATION BY STATE AGENCIES.—

21 “(I) IN GENERAL.—A State
22 agency may not use or disclose infor-
23 mation provided under clause (i) ex-
24 cept for purposes of determining the
25 eligibility of an applicant for, or an

1 enrollee in, a program referred to in
2 clause (i).

3 “(II) INFORMATION SECURITY.—

4 The State agency shall have in effect
5 data security and control policies that
6 the Secretary finds adequate to ensure
7 the security of information obtained
8 under clause (i) and to ensure that
9 access to such information is re-
10 stricted to authorized persons for pur-
11 poses of authorized uses and disclo-
12 sures.

13 “(III) PENALTY FOR MISUSE OF
14 INFORMATION.—An officer or em-
15 ployee of the State agency who fails to
16 comply with this clause shall be sub-
17 ject to the sanctions under subsection
18 (1)(2) to the same extent as if such of-
19 ficer or employee were an officer or
20 employee of the United States.

21 “(iv) PROCEDURAL REQUIREMENTS.—

22 State agencies requesting information
23 under clause (i) shall adhere to uniform
24 procedures established by the Secretary

1 governing information requests and data
2 matching under this paragraph.

3 “(v) REIMBURSEMENT OF COSTS.—
4 The State agency shall reimburse the Sec-
5 retary, in accordance with subsection
6 (k)(3), for the costs incurred by the Sec-
7 retary in furnishing the information re-
8 quested under this subparagraph.”.

9 (e) IMPROVING THE SHARING OF DATA BETWEEN
10 THE FEDERAL GOVERNMENT AND STATE MEDICAID PRO-
11 GRAMS.—

12 (1) IN GENERAL.—The Secretary of Health and
13 Human Services (in this subsection referred to as
14 the “Secretary”) shall establish a plan to encourage
15 and facilitate the participation of States in the Medi-
16 care-Medicaid Data Match Program (commonly re-
17 ferred to as the “Medi-Medi Program”) under sec-
18 tion 1893(g) of the Social Security Act (42 U.S.C.
19 1395ddd(g)).

20 (2) PROGRAM REVISIONS TO IMPROVE MEDI-
21 MEDI DATA MATCH PROGRAM PARTICIPATION BY
22 STATES.—Section 1893(g)(1)(A) of the Social Secu-
23 rity Act (42 U.S.C. 1395ddd(g)(1)(A)) is amend-
24 ed—

1 (A) in the matter preceding clause (i), by
2 inserting “or otherwise” after “eligible enti-
3 ties”;

4 (B) in clause (i)—

5 (i) by inserting “to review claims
6 data” after “algorithms”; and

7 (ii) by striking “service, time, or pa-
8 tient” and inserting “provider, service,
9 time, or patient”;

10 (C) in clause (ii)—

11 (i) by inserting “to investigate and re-
12 cover amounts with respect to suspect
13 claims” after “appropriate actions”; and

14 (ii) by striking “; and” and inserting
15 a semicolon;

16 (D) in clause (iii), by striking the period
17 and inserting “; and”; and

18 (E) by adding at end the following new
19 clause:

20 “(iv) furthering the Secretary’s de-
21 sign, development, installation, or enhance-
22 ment of an automated data system archi-
23 tecture—

24 “(I) to collect, integrate, and as-
25 sess data for purposes of program in-

1 integrity, program oversight, and ad-
2 ministration, including the Medi-Medi
3 Program; and

4 “(II) that improves the coordina-
5 tion of requests for data from
6 States.”.

7 (3) PROVIDING STATES WITH DATA ON IM-
8 PROPER PAYMENTS MADE FOR ITEMS OR SERVICES
9 PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

10 (A) IN GENERAL.—The Secretary shall de-
11 velop and implement a plan that allows each
12 State agency responsible for administering a
13 State plan for medical assistance under title
14 XIX of the Social Security Act access to rel-
15 evant data on improper or fraudulent payments
16 made under the Medicare program under title
17 XVIII of the Social Security Act (42 U.S.C.
18 1395 et seq.) for health care items or services
19 provided to dual eligible individuals.

20 (B) DUAL ELIGIBLE INDIVIDUAL DE-
21 FINED.—In this paragraph, the term “dual eli-
22 gible individual” means an individual who is en-
23 titled to, or enrolled for, benefits under part A
24 of title XVIII of the Social Security Act (42
25 U.S.C. 1395c et seq.), or enrolled for benefits

1 The health care system should embed principles that
2 take into account patient wishes.

3 (4) Decisions concerning health care, including
4 end-of-life issues, affect an increasing number of
5 Americans.

6 (5) Medical advances are prolonging life expect-
7 ancy in the United States both in acute life-threat-
8 ening situations and protracted battles with illness.
9 These advances raise new challenges surrounding
10 health care decision-making.

11 (6) The United States health care system
12 should promote consideration of a person's pref-
13 erence in health care decision-making and end-of-life
14 choices.

15 (b) COMMISSION.—The Social Security Act is amend-
16 ed by inserting after section 1150B (42 U.S.C. 1320b-
17 24) the following new section:

18 **“SEC. 1150C. COMMISSION ON IMPROVING PATIENT DI-**
19 **RECTED HEALTH CARE.**

20 “(a) PURPOSES.—The purposes of this section are
21 to—

22 “(1) provide a forum for a nationwide public
23 debate on improving patient self-determination in
24 health care decision-making;

1 “(2) identify strategies that ensure every Amer-
2 ican has the health care they want; and

3 “(3) provide recommendations to Congress that
4 result from the debate.

5 “(b) ESTABLISHMENT.—The Secretary shall estab-
6 lish an entity to be known as the Commission on Improv-
7 ing Patient Directed Health Care (referred to in this sec-
8 tion as the ‘Commission’).

9 “(c) MEMBERSHIP.—

10 “(1) NUMBER AND APPOINTMENT.—The Com-
11 mission shall be composed of 15 members. One
12 member shall be the Secretary. The Comptroller
13 General of the United States shall appoint 14 mem-
14 bers.

15 “(2) QUALIFICATIONS.—The membership of the
16 Commission shall include—

17 “(A) health care consumers impacted by
18 decision-making in advance of a health care cri-
19 sis, such as individuals of advanced age, indi-
20 viduals with chronic, terminal and mental ill-
21 nesses, family care givers, and individuals with
22 disabilities;

23 “(B) providers in settings where crucial
24 health care decision-making occurs, such as
25 those working in intensive care settings, emer-

1 agency room departments, primary care settings,
2 nursing homes, hospice, or palliative care set-
3 tings;

4 “(C) payors ensuring patients get the level
5 of care they want;

6 “(D) experts in advance care planning,
7 hospice, palliative care, information technology,
8 bioethics, aging policy, disability policy, pedi-
9 atric ethics, cultural sensitivity, psychology, and
10 health care financing;

11 “(E) individuals who represent culturally
12 diverse perspectives on patient self-determina-
13 tion and end-of-life issues; and

14 “(F) members of the faith community.

15 “(d) PERIOD OF APPOINTMENT.—Members of the
16 Commission shall be appointed for the life of the Commis-
17 sion. Any vacancies shall not affect the power and duties
18 of the Commission but shall be filled in the same manner
19 as the original appointment.

20 “(e) DESIGNATION OF THE CHAIRPERSON.—Not
21 later than 15 days after the date on which all members
22 of the Commission have been appointed, the Comptroller
23 General shall designate the chairperson of the Commis-
24 sion.

1 “(f) SUBCOMMITTEES.—The Commission may estab-
2 lish subcommittees if doing so increases the efficiency of
3 the Commission in completing tasks.

4 “(g) DUTIES.—

5 “(1) HEARINGS.—Not later than 90 days after
6 the date of designation of the chairperson under
7 subsection (e), the Commission shall hold no fewer
8 than 8 hearings to examine—

9 “(A) the current state of health care deci-
10 sion-making and advance care planning laws in
11 the United States at the Federal level and
12 across the States, as well as options for improv-
13 ing advance care planning tools, especially with
14 regard to use, portability, and storage;

15 “(B) consumer-focused approaches that
16 educate the American public about patient
17 choices, care planning, and other end-of-life
18 issues;

19 “(C) the use of comprehensive, patient-cen-
20 tered care plans by providers, the impact care
21 plans have on health care delivery and spend-
22 ing, and methods to expand the use of high
23 quality care planning tools in both public and
24 private health care systems;

1 “(D) the role of electronic medical records
2 and other technologies in improving patient-di-
3 rected health care;

4 “(E) innovative tools for improving patient
5 experience with advanced illness, such as pallia-
6 tive care, hospice, and other models;

7 “(F) the role social determinants of health,
8 such as socio-economic status, play in patient
9 self-direction in health care;

10 “(G) the use of culturally-competent tools
11 for health care decision-making;

12 “(H) strategies for educating providers
13 and increasing provider engagement on care
14 planning, palliative care, hospice care, and
15 other issues surrounding honoring patient
16 choices;

17 “(I) the sociological and psychological fac-
18 tors that influence health care decision-making
19 and end-of-life choices; and

20 “(J) the role of spirituality and religion in
21 patient self-determination in health care.

22 “(2) ADDITIONAL HEARINGS.—The Commission
23 may hold additional hearings on subjects other than
24 those listed in paragraph (1) so long as such hear-
25 ings are determined necessary by the Commission in

1 carrying out the purposes of this section. Such addi-
2 tional hearings do not have to be completed within
3 the time period specified but shall not delay the
4 other activities of the Commission under this sec-
5 tion.

6 “(3) NUMBER AND LOCATION OF HEARINGS
7 AND ADDITIONAL HEARINGS.—The Commission shall
8 hold no fewer than 8 hearings as indicated in para-
9 graph (1) and in sufficient number in order to re-
10 ceive information that reflects—

11 “(A) the geographic differences throughout
12 the United States;

13 “(B) diverse populations; and

14 “(C) a balance among urban and rural
15 populations.

16 “(4) INTERACTIVE TECHNOLOGY.—The Com-
17 mission may encourage public participation in hear-
18 ings through interactive technology and other means
19 as determined appropriate by the Commission.

20 “(5) REPORT TO THE AMERICAN PEOPLE ON
21 PATIENT DIRECTED HEALTH CARE.—Not later than
22 90 days after the hearings described in paragraphs
23 (1) and (2) are completed, the Commission shall
24 prepare and make available to health care consumers
25 through the Internet and other appropriate public

1 channels, a report to be entitled, ‘Report to the
2 American People on Patient Directed Health Care’.
3 Such a report shall be understandable to the general
4 public and include—

5 “(A) a summary of—

6 “(i) the hearings described in such
7 paragraphs;

8 “(ii) how the current health care sys-
9 tem empowers and informs decision-mak-
10 ing in advance of a health care crisis;

11 “(iii) factors that contribute to the
12 provision of health care that does not ad-
13 here to patient wishes;

14 “(iv) the impact of care that does not
15 follow patient choices, particularly at the
16 end-of-life, on patients, families, providers,
17 spending, and the health care system;

18 “(v) the laws surrounding advance
19 care planning and health care decision-
20 making including issues of portability, use,
21 and storage;

22 “(vi) consumer-focused approaches to
23 education of the American public about pa-
24 tient choices, care planning, and other end-
25 of-life issues;

1 “(vii) the role of care plans in health
2 care decision-making;

3 “(viii) the role of providers in ensur-
4 ing patients receive the care they want;

5 “(ix) the role of electronic medical
6 records and other technologies in improv-
7 ing patient directed health care;

8 “(x) the impact of social determinants
9 on patient self-direction in health care
10 services;

11 “(xi) the use of culturally competent
12 methods for health care decision-making;

13 “(xii) the sociological and psycho-
14 logical factors that influence patient self-
15 determination; and

16 “(xiii) the role of spirituality and reli-
17 gion in health care decision-making and
18 end-of-life care;

19 “(B) best practices from communities, pro-
20 viders, and payors that document patient wish-
21 es and provide health care that adheres to those
22 wishes; and

23 “(C) information on educating providers
24 about health care decision-making and end-of-
25 life issues.

1 “(6) INTERIM REQUIREMENTS.—Not later than
2 180 days after the date of completion of the hear-
3 ings, the Commission shall prepare and make avail-
4 able to the public through the Internet and other ap-
5 propriate public channels, an interim set of rec-
6 ommendations on patient self-determination in
7 health care and ways to improve and strengthen the
8 health care system based on the information and
9 preferences expressed at the community meetings.
10 There shall be a 90-day public comment period on
11 such recommendations.

12 “(h) RECOMMENDATIONS.—Not later than 120 days
13 after the expiration of the public comment period de-
14 scribed in subsection (g)(6), the Commission shall submit
15 to Congress and the President a final set of recommenda-
16 tions. The recommendations must be comprehensive and
17 detailed. The recommendations must contain rec-
18 ommendations or proposals for legislative or administra-
19 tive action as the Commission deems appropriate, includ-
20 ing proposed legislative language to carry out the rec-
21 ommendations or proposals.

22 “(i) ADMINISTRATION.—

23 “(1) EXECUTIVE DIRECTOR.—There shall be an
24 Executive Director of the Commission who shall be

1 appointed by the chairperson of the Commission in
2 consultation with the members of the Commission.

3 “(2) COMPENSATION.—While serving on the
4 business of the Commission (including travel time),
5 a member of the Commission shall be entitled to
6 compensation at the per diem equivalent of the rate
7 provided for level IV of the Executive Schedule
8 under section 5315 of title 5, United States Code,
9 and while so serving away from home and the mem-
10 ber’s regular place of business, a member may be al-
11 lowed travel expenses, as authorized by the chair-
12 person of the Commission. For purposes of pay and
13 employment benefits, rights, and privileges, all per-
14 sonnel of the Commission shall be treated as if they
15 were employees of the Senate.

16 “(3) INFORMATION FROM FEDERAL AGEN-
17 CIES.—The Commission may secure directly from
18 any Federal department or agency such information
19 as the Commission considers necessary to carry out
20 this section. Upon request of the Commission the
21 head of such department or agency shall furnish
22 such information.

23 “(4) POSTAL SERVICES.—The Commission may
24 use the United States mails in the same manner and

1 under the same conditions as other departments and
2 agencies of the Federal Government.

3 “(j) DETAIL.—Not more than 4 Federal Government
4 employees employed by the Department of Labor, 4 Fed-
5 eral Government employees employed by the Social Secu-
6 rity Administration, and 8 Federal Government employees
7 employed by the Department of Health and Human Serv-
8 ices may be detailed to the Commission under this section
9 without further reimbursement. Any detail of an employee
10 shall be without interruption or loss of civil service status
11 or privilege.

12 “(k) TEMPORARY AND INTERMITTENT SERVICES.—
13 The chairperson of the Commission may procure tem-
14 porary and intermittent services under section 3109(b) of
15 title 5, United States Code, at rates for individuals which
16 do not exceed the daily equivalent of the annual rate of
17 basic pay prescribed for level V of the Executive Schedule
18 under section 5316 of such title.

19 “(l) ANNUAL REPORT.—Not later than 1 year after
20 the date of enactment of this Act, and annually thereafter
21 during the existence of the Commission, the Commission
22 shall report to Congress and make public a detailed de-
23 scription of the expenditures of the Commission used to
24 carry out its duties under this section.

1 “(m) SUNSET OF COMMISSION.—The Commission
2 shall terminate on the date that is 3 years after the date
3 on which all the members of the Commission have been
4 appointed under subsection (c)(1) and appropriations are
5 first made available to carry out this section.

6 “(n) ADMINISTRATION REVIEW AND COMMENTS.—
7 Not later than 45 days after receiving the final rec-
8 ommendations of the Commission under subsection (h),
9 the President shall submit a report to Congress which
10 shall contain—

11 “(1) additional views and comments on such
12 recommendations; and

13 “(2) recommendations for such legislation and
14 administrative action as the President considers ap-
15 propriate.

16 “(o) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) IN GENERAL.—There are authorized to be
18 appropriated to carry out this section, \$3,000,000
19 for each of fiscal years 2014 and 2015.

20 “(2) REPORT TO THE AMERICAN PEOPLE ON
21 PATIENT DIRECTED HEALTH CARE.—There are au-
22 thorized to be appropriated for the preparation and
23 dissemination of the Report to the American People
24 on Patient Directed Health Care described in sub-

1 section (g)(5), \$1,000,000 for the fiscal year in
2 which the report is required to be submitted.”.

3 **SEC. 402. EXPANSION OF THE DEFINITION OF INPATIENT**
4 **HOSPITAL SERVICES FOR CERTAIN CANCER**
5 **HOSPITALS.**

6 Section 1861(b) of the Social Security Act (42 U.S.C.
7 1395x(b)) is amended—

8 (1) in paragraph (3)—

9 (A) by inserting “(A)” after “(3)”;

10 (B) by adding “and” after the semicolon
11 at the end; and

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

14 “(B) subject to the third sentence of this
15 subsection, with respect to a hospital that—

16 “(i) is described in section
17 1886(d)(1)(B)(v); and

18 “(ii) as of the date of the enactment
19 of the Medicare SGR Repeal and Bene-
20 ficiary Access Improvement Act of 2014, is
21 located in the same building, or on the
22 same campus, as another hospital (as de-
23 scribed in sections 412.22(e) and 412.22(f)
24 of title 42, Code of Federal Regulations, as
25 in effect on such date of enactment);

1 items and services described in paragraphs (1)
2 and (2) furnished on or after October 1, 2014,
3 by such hospital described in section
4 1886(d)(1)(B)(v) or by others under arrange-
5 ments with them made by the hospital;” and
6 (2) by adding at the end the following new
7 flush sentence:

8 “Paragraph (3)(B) shall only apply to payments with re-
9 spect to the total number of the hospital’s patient days
10 at any satellite of the hospital or such days at another
11 hospital providing services under arrangements to the hos-
12 pital, determined as of the date of the enactment of the
13 Medicare SGR Repeal and Beneficiary Access Improve-
14 ment Act of 2014.”.

15 **SEC. 403. QUALITY MEASURES FOR CERTAIN POST-ACUTE**
16 **CARE PROVIDERS RELATING TO NOTICE AND**
17 **TRANSFER OF PATIENT HEALTH INFORMA-**
18 **TION AND PATIENT CARE PREFERENCES.**

19 (a) DEVELOPMENT.—The Secretary of Health and
20 Human Services (in this section referred to as the “Sec-
21 retary”) shall provide for the development of one or more
22 quality measures under title XVIII of the Social Security
23 Act (42 U.S.C. 1395 et seq.) to accurately communicate
24 the existence and provide for the transfer of patient health
25 information and patient care preferences when an indi-

1 vidual transitions from a hospital to return home or move
2 to other post-acute care settings.

3 (b) USE OF MEASURE DEVELOPERS.—The Secretary
4 shall arrange for the development of such measures by ap-
5 propriate measure developers.

6 (c) ENDORSEMENT.—The Secretary shall arrange for
7 such developed measures to be submitted for endorsement
8 to a consensus-based entity as described in section
9 1890(a) of the Social Security Act (42 U.S.C.
10 1395aaa(a)).

11 (d) USE OF MEASURES.—The Secretary shall,
12 through notice and comment rulemaking, use such meas-
13 ures under the quality reporting programs with respect
14 to—

15 (1) inpatient hospitals under section
16 1886(b)(3)(B)(viii) of the Social Security Act (42
17 U.S.C. 1395ww(b)(3)(B)(viii));

18 (2) skilled nursing facilities under section
19 1888(e) of such Act (42 U.S.C. 1395yy(e));

20 (3) home health services under section
21 1895(b)(3)(B)(v) of such Act (42 U.S.C.
22 1395fff(b)(3)(B)(v)); and

23 (4) other providers of services (as defined in
24 section 1861(u) of such Act) and suppliers (as de-

1 (b) INTERESTED STAKEHOLDERS.—In subsection
2 (a), the term “interested stakeholders” means the fol-
3 lowing:

4 (1) Hospitals.

5 (2) Physicians

6 (3) Medicare administrative contractors under
7 section 1874A of the Social Security Act (42 U.S.C.
8 1395kk–1).

9 (4) Recovery audit contractors under section
10 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

11 (5) Other parties determined appropriate by the
12 Secretary.

13 **SEC. 405. TRANSPARENCY OF REASONS FOR EXCLUDING**
14 **ADDITIONAL PROCEDURES FROM THE MEDI-**
15 **CARE AMBULATORY SURGICAL CENTER (ASC)**
16 **APPROVED LIST.**

17 Section 1833(i)(1) of the Social Security Act (42
18 U.S.C. 1395l(i)(1)) is amended by adding at the end the
19 following: “In updating such lists for application in years
20 beginning after December 31, 2014, for each procedure
21 that was not proposed but was requested to be included
22 on such lists during the public comment where the Sec-
23 retary does not finalize (in the final rule updating such
24 lists) to so include, the Secretary shall describe in such

1 final rule the specific safety criteria for not including such
2 requested procedure on such lists.”.

3 **SEC. 406. SUPERVISION IN CRITICAL ACCESS HOSPITALS.**

4 (a) GENERAL SUPERVISION IN CRITICAL ACCESS
5 HOSPITALS.—Section 1834(g) of the Social Security Act
6 (42 U.S.C. 1395m(g)) is amended by adding at the end
7 the following new paragraph:

8 “(6) SUPERVISION.—In the case of services fur-
9 nished on or after the date of the enactment of this
10 paragraph, the minimum level of supervision with re-
11 spect to outpatient therapeutic critical access hos-
12 pital services shall be general supervision (as defined
13 by the Secretary).”.

14 (b) SUPERVISION OF CARDIAC AND PULMONARY RE-
15 HABILITATION PROGRAMS IN CRITICAL ACCESS HOS-
16 PITALS.—Section 1861(eee)(2)(B) of the Social Security
17 Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting
18 “, or in the case of a critical access hospital, a physician,
19 or (beginning on the date of enactment of Medicare SGR
20 Repeal and Beneficiary Access Improvement Act of 2014)
21 a nurse practitioner, clinical nurse specialist, or physician
22 assistant (as such terms are defined in subsection
23 (aa)(5)),” after “a physician”.

1 **SEC. 407. REQUIRING STATE LICENSURE OF BIDDING ENTI-**
2 **TIES UNDER THE COMPETITIVE ACQUISITION**
3 **PROGRAM FOR CERTAIN DURABLE MEDICAL**
4 **EQUIPMENT, PROSTHETICS, ORTHOTICS, AND**
5 **SUPPLIES (DMEPOS).**

6 Section 1847(a)(1) of the Social Security Act (42
7 U.S.C. 1395w-3(a)(1)) is amended by adding at the end
8 the following new subparagraph:

9 “(G) REQUIRING STATE LICENSURE OF
10 BIDDING ENTITIES.—With respect to rounds of
11 competitions beginning on or after the date of
12 enactment of this subparagraph, the Secretary
13 may only accept a bid from an entity for an
14 area if the entity meets applicable State licen-
15 sure requirements for such area for all items in
16 such bid for a product category.”.

17 **SEC. 408. RECOGNITION OF ATTENDING PHYSICIAN ASSIST-**
18 **ANTS AS ATTENDING PHYSICIANS TO SERVE**
19 **HOSPICE PATIENTS.**

20 (a) RECOGNITION OF ATTENDING PHYSICIAN AS-
21 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOS-
22 PICE PATIENTS.—

23 (1) IN GENERAL.—Section 1861(dd)(3)(B) of
24 the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))
25 is amended—

1 (A) by striking “or nurse” and inserting “,
2 the nurse”; and

3 (B) by inserting “, or the physician assist-
4 ant (as defined in such subsection)” after “sub-
5 section (aa)(5))”.

6 (2) CLARIFICATION OF HOSPICE ROLE OF PHY-
7 SICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of
8 the Social Security Act (42 U.S.C.
9 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a
10 physician assistant” after “a nurse practitioner”.

11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to items and services furnished on
13 or after October 1, 2015.

14 **SEC. 409. REMOTE PATIENT MONITORING PILOT**
15 **PROJECTS.**

16 (a) PILOT PROJECTS.—

17 (1) IN GENERAL.—Not later than 9 months
18 after the date of the enactment of this Act, the Sec-
19 retary shall conduct pilot projects under title XVIII
20 of the Social Security Act for the purpose of pro-
21 viding incentives to home health agencies to furnish
22 remote patient monitoring services that reduce ex-
23 penditures under such title.

24 (2) SITE REQUIREMENTS.—

1 (A) URBAN AND RURAL.—The Secretary
2 shall conduct the pilot projects under this sec-
3 tion in both urban and rural areas.

4 (B) SITE IN A SMALL STATE.—The Sec-
5 retary shall conduct at least 1 of the pilot
6 projects in a State with a population of less
7 than 1,000,000.

8 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
9 OF PROJECTS.—

10 (1) IN GENERAL.—The Secretary shall specify
11 the criteria for identifying those Medicare bene-
12 ficiaries who shall be considered within the scope of
13 the pilot projects under this section for purposes of
14 the application of subsection (c) and for the assess-
15 ment of the effectiveness of the home health agency
16 in achieving the objectives of this section.

17 (2) CRITERIA.—The criteria specified under
18 paragraph (1)—

19 (A) shall include conditions and clinical
20 circumstances, including congestive heart fail-
21 ure, diabetes, and chronic pulmonary obstruc-
22 tive disease, and other conditions determined
23 appropriate by the Secretary; and

24 (B) may provide for the inclusion in the
25 projects of Medicare beneficiaries who begin re-

1 ceiving home health services under title XVIII
2 of the Social Security Act after the date of the
3 implementation of the projects.

4 (c) INCENTIVES.—

5 (1) PERFORMANCE TARGETS.—The Secretary
6 shall establish for each home health agency partici-
7 pating in a pilot project under this section a per-
8 formance target using one of the following meth-
9 odologies, as determined appropriate by the Sec-
10 retary:

11 (A) ADJUSTED HISTORICAL PERFORMANCE
12 TARGET.—The Secretary shall establish for the
13 agency—

14 (i) a base expenditure amount equal
15 to the average total payments made under
16 parts A, B, and D of title XVIII of the So-
17 cial Security Act for Medicare beneficiaries
18 determined to be within the scope of the
19 pilot project in a base period determined
20 by the Secretary; and

21 (ii) an annual per capita expenditure
22 target for such beneficiaries, reflecting the
23 base expenditure amount adjusted for risk,
24 changes in costs, and growth rates.

1 (B) COMPARATIVE PERFORMANCE TAR-
2 GET.—The Secretary shall establish for the
3 agency a comparative performance target equal
4 to the average total payments made under such
5 parts A, B, and D during the pilot project for
6 comparable individuals in the same geographic
7 area that are not determined to be within the
8 scope of the pilot project.

9 (2) PAYMENT.—Subject to paragraph (3), the
10 Secretary shall pay to each home health agency par-
11 ticipating in a pilot project a payment for each year
12 under the pilot project equal to a 75 percent share
13 of the total Medicare cost savings realized for such
14 year relative to the performance target under para-
15 graph (1).

16 (3) LIMITATION ON EXPENDITURES.—The Sec-
17 retary shall limit payments under this section in
18 order to ensure that the aggregate expenditures
19 under title XVIII of the Social Security Act (includ-
20 ing payments under this subsection) do not exceed
21 the amount that the Secretary estimates would have
22 been expended if the pilot projects under this section
23 had not been implemented, including any reasonable
24 costs incurred by the Secretary in the administration
25 of the pilot projects.

1 (4) NO DUPLICATION IN PARTICIPATION IN
2 SHARED SAVINGS PROGRAMS.—A home health agen-
3 cy that participates in any of the following shall not
4 be eligible to participate in the pilot projects under
5 this section:

6 (A) A model tested or expanded under sec-
7 tion 1115A of the Social Security Act (42
8 U.S.C. 1315a) that involves shared savings
9 under title XVIII of such Act or any other pro-
10 gram or demonstration project that involves
11 such shared savings.

12 (B) The independence at home medical
13 practice demonstration program under section
14 1866E of such Act (42 U.S.C. 1395cc-5).

15 (d) WAIVER AUTHORITY.—The Secretary may waive
16 such provisions of titles XI and XVIII of the Social Secu-
17 rity Act as the Secretary determines to be appropriate for
18 the conduct of the pilot projects under this section.

19 (e) REPORT TO CONGRESS.—Not later than 3 years
20 after the date that the first pilot project under this section
21 is implemented, the Secretary shall submit to Congress a
22 report on the projects. Such report shall contain—

23 (1) a detailed description of the projects, in-
24 cluding any changes in clinical outcomes for Medi-
25 care beneficiaries under the projects, Medicare bene-

1 ficiary satisfaction under the projects, utilization of
2 items and services under parts A, B, and D of title
3 XVIII of the Social Security Act by Medicare bene-
4 ficiaries under the projects, and Medicare per-bene-
5 ficiary and Medicare aggregate spending under the
6 projects;

7 (2) a detailed description of issues related to
8 the expansion of the projects under subsection (f);

9 (3) recommendations for such legislation and
10 administrative actions as the Secretary considers ap-
11 propriate; and

12 (4) other items considered appropriate by the
13 Secretary.

14 (f) EXPANSION.—If the Secretary determines that
15 any of the pilot projects under this section enhance health
16 outcomes for Medicare beneficiaries and reduce expendi-
17 tures under title XVIII of the Social Security Act, the Sec-
18 retary shall initiate comparable projects in additional
19 areas.

20 (g) PAYMENTS HAVE NO EFFECT ON OTHER MEDI-
21 CARE PAYMENTS TO HOME HEALTH AGENCIES.—A pay-
22 ment under this section shall have no effect on the amount
23 of payments that a home health agency would otherwise
24 receive under title XVIII of the Social Security Act for
25 the provision of home health services.

1 (h) STUDY AND REPORT ON THE APPROPRIATE
2 VALUATION FOR REMOTE PATIENT MONITORING SERV-
3 ICES UNDER THE MEDICARE PHYSICIAN FEE SCHED-
4 ULE.—

5 (1) STUDY.—The Secretary shall conduct a
6 study on the appropriate valuation for remote pa-
7 tient monitoring services under the Medicare physi-
8 cian fee schedule under section 1848 of the Social
9 Security Act (42 U.S.C. 1395w-4) in order to accu-
10 rately reflect the resources involved in furnishing
11 such services.

12 (2) REPORT.—Not later than 6 months after
13 the date of the enactment of this Act, the Secretary
14 shall submit to Congress a report on the study con-
15 ducted under paragraph (1), together with such rec-
16 ommendations as the Secretary determines appro-
17 priate.

18 (i) DEFINITIONS.—In this section:

19 (1) HOME HEALTH AGENCY.—The term “home
20 health agency” has the meaning given that term in
21 section 1861(o) of the Social Security Act (42
22 U.S.C. 1395x(o)).

23 (2) REMOTE PATIENT MONITORING SERV-
24 ICES.—

1 (A) IN GENERAL.—The term “remote pa-
2 tient monitoring services” means services fur-
3 nished in the home using remote patient moni-
4 toring technology which—

5 (i) shall include patient monitoring or
6 patient assessment; and

7 (ii) may include in-home technology-
8 based professional consultations, patient
9 training services, clinical observation,
10 treatment, and any additional services that
11 utilize technologies specified by the Sec-
12 retary.

13 (B) LIMITATION.—The term “remote pa-
14 tient monitoring services” shall not include a
15 telecommunication that consists solely of a tele-
16 phone audio conversation, facsimile, or elec-
17 tronic text mail between a health care profes-
18 sional and a patient.

19 (3) REMOTE PATIENT MONITORING TECH-
20 NOLOGY.—The term “remote patient monitoring
21 technology” means a coordinated system that uses
22 one or more home-based or mobile monitoring de-
23 vices that automatically transmit vital sign data or
24 information on activities of daily living and may in-
25 clude responses to assessment questions collected on

1 the devices wirelessly or through a telecommuni-
2 cations connection to a server that complies with the
3 Federal regulations (concerning the privacy of indi-
4 vidually identifiable health information) promulgated
5 under section 264(c) of the Health Insurance Port-
6 ability and Accountability Act of 1996, as part of an
7 established plan of care for that patient that in-
8 cludes the review and interpretation of that data by
9 a health care professional.

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

12 **SEC. 410. COMMUNITY-BASED INSTITUTIONAL SPECIAL**
13 **NEEDS PLAN DEMONSTRATION PROGRAM.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services (referred to in this section as the “Sec-
16 retary”) shall establish a Community-Based Institutional
17 Special Needs Plan (CBI-SNP) demonstration program to
18 prevent and delay institutionalization under Medicaid
19 among targeted low-income Medicare beneficiaries.

20 (b) ESTABLISHMENT.—The Secretary shall enter into
21 agreements with not more than 5 specialized MA plans
22 for special needs individuals, as defined in section
23 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C.
24 1395w–28(b)(6)(B)(i)), to conduct the CBI-SNP dem-
25 onstration program. Under the CBI-SNP demonstration

1 program, a targeted low-income Medicare beneficiary shall
2 receive, as supplemental benefits under section 1852(a)(3)
3 of such Act (42 U.S.C. 1395w-22(a)(3)), long-term care
4 services or supports that—

5 (1) the Secretary determines appropriate for
6 the purposes of the CBI-SNP demonstration pro-
7 gram; and

8 (2) for which payment may be made under the
9 State plan under title XIX of such Act (42 U.S.C.
10 1396 et seq.) of the State in which the targeted low-
11 income Medicare beneficiary is located.

12 (c) ELIGIBLE PLANS.—To be eligible to participate
13 in the CBI-SNP demonstration program, a specialized MA
14 plan for special needs individuals must—

15 (1) serve special needs individuals (as defined
16 in section 1859(b)(6)(B)(i) of the Social Security
17 Act (42 U.S.C. 1395w-28(b)(6)(B)(i));

18 (2) have experience in offering special needs
19 plans for nursing home-eligible, non-institutionalized
20 Medicare beneficiaries who live in the community;

21 (3) be located in a State that the Secretary has
22 determined will participate in the CBI-SNP dem-
23 onstration program by agreeing to make available
24 data necessary for purposes of conducting the inde-

1 pendent evaluation required under subsection (f);
2 and

3 (4) meet such other criteria as the Secretary
4 may require.

5 (d) TARGETED LOW-INCOME MEDICARE BENE-
6 FICIARY DEFINED.—In this section, the term “targeted
7 low-income Medicare beneficiary” means a Medicare bene-
8 ficiary who—

9 (1) is enrolled in a specialized MA plan for spe-
10 cial needs individuals that has been selected to par-
11 ticipate in the CBI-SNP demonstration program;

12 (2) is a subsidy eligible individual (as defined in
13 section 1860D–14(a)(3)(A) of the Social Security
14 Act (42 U.S.C. 1395w-114(a)(3)(A)); and

15 (3) is unable to perform 2 or more activities of
16 daily living (as defined in section 7702B(e)(2)(B) of
17 the Internal Revenue Code of 1986).

18 (e) IMPLEMENTATION DEADLINE; DURATION.—The
19 CBI-SNP demonstration program shall be implemented
20 not later than January 1, 2016, and shall be conducted
21 for a period of 3 years.

22 (f) INDEPENDENT EVALUATION AND REPORTS.—

23 (1) INDEPENDENT EVALUATION.—Not later
24 than 2 years after the completion of the CBI-SNP
25 demonstration program, the Secretary shall provide

1 for the evaluation of the CBI-SNP demonstration
2 program by an independent third party. The evalua-
3 tion shall determine whether the CBI-SNP dem-
4 onstration program has improved patient care and
5 quality of life for the targeted low-income Medicare
6 beneficiaries participating in the CBI-SNP dem-
7 onstration program. Specifically, the evaluation shall
8 determine if the CBI-SNP demonstration program
9 has—

10 (A) reduced hospitalizations or re-hos-
11 pitalizations;

12 (B) reduced Medicaid nursing home facility
13 stays; and

14 (C) reduced spenddown of income and as-
15 sets for purposes of becoming eligible for Med-
16 icaid.

17 (2) REPORTS.—Not later than 3 years after the
18 completion of the CBI-SNP demonstration program,
19 the Secretary shall submit to Congress a report con-
20 taining the results of the evaluation conducted under
21 paragraph (1), together with such recommendations
22 for legislative or administrative action as the Sec-
23 retary determines appropriate.

24 (g) FUNDING.—

1 (1) FUNDING FOR IMPLEMENTATION.—For
2 purposes of carrying out the demonstration program
3 under this section (other than the evaluation and re-
4 port under subsection (f)), the Secretary shall pro-
5 vide for the transfer from the Federal Hospital In-
6 surance Trust Fund under section 1817 of the So-
7 cial Security Act (42 U.S.C. 1395i) and the Federal
8 Supplementary Medical Insurance Trust Fund under
9 section 1841 of such Act (42 U.S.C. 1395t), in such
10 proportion as the Secretary determines appropriate,
11 of \$3,000,000 to the Centers for Medicare & Med-
12 icaid Services Program Management Account.

13 (2) FUNDING FOR EVALUATION AND REPORT.—
14 For purposes of carrying out the evaluation and re-
15 port under subsection (f), the Secretary shall provide
16 for the transfer from the Federal Hospital Insurance
17 Trust Fund under such section 1817 and the Fed-
18 eral Supplementary Medical Insurance Trust Fund
19 under such section 1841, in such proportion as the
20 Secretary determines appropriate, of \$500,000.

21 (3) AVAILABILITY.—Amounts transferred under
22 paragraph (1) or (2) shall remain available until ex-
23 pended.

24 (h) BUDGET NEUTRALITY.—In conducting the CBI-
25 SNP demonstration program, the Secretary shall ensure

1 that the aggregate payments made by the Secretary do
2 not exceed the amount which the Secretary estimates
3 would have been expended under titles XVIII and XIX
4 of the Social Security Act (42 U.S.C. 1395 et seq., 1396
5 et seq.) if the CBI-SNP demonstration program had not
6 been implemented.

7 (i) PAPERWORK REDUCTION ACT.—Chapter 35 of
8 title 44, United States Code, shall not apply to the testing
9 and evaluation of the CBI-SNP demonstration program
10 under this section.

11 **SEC. 411. APPLYING CMMI WAIVER AUTHORITY TO PACE IN**
12 **ORDER TO FOSTER INNOVATIONS.**

13 (a) CMMI WAIVER AUTHORITY.—Subsection (d)(1)
14 of section 1115A of the Social Security Act (42 U.S.C.
15 1315a) is amended—

16 (1) by inserting “(other than subsections
17 (b)(1)(A) and (c)(5) of section 1894)” after
18 “XVIII”; and

19 (2) by striking “and 1903(m)(2)(A)(iii)” and
20 inserting “1903(m)(2)(A)(iii), and 1934 (other than
21 subsections (b)(1)(A) and (c)(5) of such section)”.

22 (b) SENSE OF THE SENATE.—It is the sense of the
23 Senate that the Secretary of Health and Human Services
24 should use the waiver authority provided under the
25 amendments made by this section to provide, in a budget

1 neutral manner, programs of all-inclusive care for the el-
2 derly (PACE programs) with increased operational flexi-
3 bility to support the ability of such programs to improve
4 and innovate and to reduce technical and administrative
5 barriers that have hindered enrollment in such programs.

6 **SEC. 412. IMPROVE AND MODERNIZE MEDICAID DATA SYS-**
7 **TEMS AND REPORTING.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services shall implement a strategic plan to in-
10 crease the usefulness of data about State Medicaid pro-
11 grams reported by States to the Centers for Medicare &
12 Medicaid Services. The strategic plan shall address
13 redundancies and gaps in Medicaid data systems and re-
14 porting through improvements to, and modernization of,
15 computer and data systems. Areas for improvement under
16 the plan shall include (but not be limited to) the following:

17 (1) The reporting of encounter data by man-
18 aged care plans.

19 (2) The timeliness and quality of reported data,
20 including enrollment data.

21 (3) The consistency of data reported from mul-
22 tiple sources.

23 (4) Information about State program policies.

24 (b) IMPLEMENTATION STATUS REPORT.—Not later
25 than 1 year after the date of enactment of this Act, the

1 Secretary of Health and Human Services shall submit a
2 report to Congress on the status of the implementation
3 of the strategic plan required under subsection (a).

4 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
5 authorized to be appropriated to the Secretary of Health
6 and Human Services for the period of fiscal years 2015
7 through 2019, such sums as may be necessary to carry
8 out this section.

9 **SEC. 413. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS**
10 **TRUSTS.**

11 (a) IN GENERAL.—Section 1917(d)(4)(A) of the So-
12 cial Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended
13 by inserting “the individual,” after “for the benefit of such
14 individual by”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to trusts established on or after
17 the date of the enactment of this Act.

18 **SEC. 414. HELPING ENSURE LIFE- AND LIMB-SAVING AC-**
19 **CESS TO PODIATRIC PHYSICIANS.**

20 (a) INCLUDING PODIATRISTS AS PHYSICIANS UNDER
21 THE MEDICAID PROGRAM.—

22 (1) IN GENERAL.—Section 1905(a)(5)(A) of the
23 Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is
24 amended by striking “section 1861(r)(1)” and in-
25 serting “paragraphs (1) and (3) of section 1861(r)”.

1 (2) EFFECTIVE DATE.—

2 (A) IN GENERAL.—Except as provided in
3 subparagraph (B), the amendment made by
4 paragraph (1) shall apply to services furnished
5 on or after the date of enactment of this Act.

6 (B) EXTENSION OF EFFECTIVE DATE FOR
7 STATE LAW AMENDMENT.—In the case of a
8 State plan under title XIX of the Social Secu-
9 rity Act (42 U.S.C. 1396 et seq.) which the
10 Secretary of Health and Human Services deter-
11 mines requires State legislation in order for the
12 plan to meet the additional requirement im-
13 posed by the amendment made by paragraph
14 (1), the State plan shall not be regarded as fail-
15 ing to comply with the requirements of such
16 title solely on the basis of its failure to meet
17 these additional requirements before the first
18 day of the first calendar quarter beginning after
19 the close of the first regular session of the
20 State legislature that begins after the date of
21 enactment of this Act. For purposes of the pre-
22 vious sentence, in the case of a State that has
23 a 2-year legislative session, each year of the ses-
24 sion is considered to be a separate regular ses-
25 sion of the State legislature.

1 (b) MODIFICATIONS TO REQUIREMENTS FOR DIA-
2 BETIC SHOES TO BE INCLUDED UNDER MEDICAL AND
3 OTHER HEALTH SERVICES UNDER MEDICARE.—

4 (1) IN GENERAL.—Section 1861(s)(12) of the
5 Social Security Act (42 U.S.C. 1395x(s)(12)) is
6 amended to read as follows:

7 “(12) subject to section 4072(e) of the Omni-
8 bus Budget Reconciliation Act of 1987, extra-depth
9 shoes with inserts or custom molded shoes (in this
10 paragraph referred to as ‘therapeutic shoes’) with
11 inserts for an individual with diabetes, if—

12 “(A) the physician who is managing the in-
13 dividual’s diabetic condition—

14 “(i) documents that the individual has
15 diabetes;

16 “(ii) certifies that the individual is
17 under a comprehensive plan of care related
18 to the individual’s diabetic condition; and

19 “(iii) documents agreement with the
20 prescribing podiatrist or other qualified
21 physician (as established by the Secretary)
22 that it is medically necessary for the indi-
23 vidual to have such extra-depth shoes with
24 inserts or custom molded shoes with in-
25 serts;

1 “(B) the therapeutic shoes are prescribed
2 by a podiatrist or other qualified physician (as
3 established by the Secretary) who—

4 “(i) examines the individual and de-
5 termines the medical necessity for the indi-
6 vidual to receive the therapeutic shoes; and

7 “(ii) communicates in writing the
8 medical necessity to the physician de-
9 scribed in subparagraph (A) for the indi-
10 vidual to have therapeutic shoes along with
11 findings that the individual has peripheral
12 neuropathy with evidence of callus forma-
13 tion, a history of pre-ulcerative calluses, a
14 history of previous ulceration, foot deform-
15 ity, previous amputation, or poor circula-
16 tion; and

17 “(C) the therapeutic shoes are fitted and
18 furnished by a podiatrist or other qualified sup-
19 plier (as established by the Secretary), such as
20 a pedorthist or orthotist, who is not the physi-
21 cian described in subparagraph (A) (unless the
22 Secretary finds that the physician is the only
23 such qualified individual in the area);”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply with respect to items
3 and services furnished on or after January 1, 2015.

4 **SEC. 415. DEMONSTRATION PROGRAMS TO IMPROVE COM-**
5 **MUNITY MENTAL HEALTH SERVICES.**

6 (a) CRITERIA FOR CERTIFIED COMMUNITY BEHAV-
7 IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-
8 ONSTRATION PROGRAMS.—

9 (1) PUBLICATION.—Not later than September
10 1, 2015, the Secretary shall publish criteria for a
11 clinic to be certified by a State as a certified com-
12 munity behavioral health clinic for purposes of par-
13 ticipating in a demonstration program conducted
14 under subsection (d).

15 (2) REQUIREMENTS.—The criteria published
16 under this subsection shall include criteria with re-
17 spect to the following:

18 (A) STAFFING.—Staffing requirements, in-
19 cluding criteria that staff have diverse discipli-
20 nary backgrounds, have necessary State-re-
21 quired license and accreditation, and are cul-
22 turally and linguistically trained to serve the
23 needs of the clinic’s patient population.

24 (B) AVAILABILITY AND ACCESSIBILITY OF
25 SERVICES.—Availability and accessibility of

1 services, including crisis management services
2 that are available and accessible 24 hours a
3 day, the use of a sliding scale for payment, and
4 no rejection for services or limiting of services
5 on the basis of a patient's ability to pay or a
6 place of residence.

7 (C) CARE COORDINATION.—Care coordina-
8 tion, including requirements to coordinate care
9 across settings and providers to ensure seamless
10 transitions for patients across the full spectrum
11 of health services including acute, chronic, and
12 behavioral health needs. Care coordination re-
13 quirements shall include partnerships or formal
14 contracts with the following:

15 (i) Federally-qualified health centers
16 (and as applicable, rural health clinics) to
17 provide Federally-qualified health center
18 services (and as applicable, rural health
19 clinic services) to the extent such services
20 are not provided directly through the cer-
21 tified community behavioral health clinic.

22 (ii) Inpatient psychiatric facilities and
23 substance use detoxification, post-detoxi-
24 fication step-down services, and residential
25 programs.

1 (iii) Other community or regional
2 services, supports, and providers, including
3 schools, child welfare agencies, juvenile and
4 criminal justice agencies and facilities, In-
5 dian Health Service youth regional treat-
6 ment centers, State licensed and nationally
7 accredited child placing agencies for thera-
8 peutic foster care service, and other social
9 and human services.

10 (iv) Department of Veterans Affairs
11 medical centers, independent outpatient
12 clinics, drop-in centers, and other facilities
13 of the Department as defined in section
14 1801 of title 38, United States Code.

15 (v) Inpatient acute care hospitals and
16 hospital outpatient clinics.

17 (D) SCOPE OF SERVICES.—Provision (in a
18 manner reflecting person-centered care) of the
19 following services which, if not available directly
20 through the certified community behavioral
21 health clinic, are provided or referred through
22 formal relationships with other providers:

23 (i) Crisis mental health services, in-
24 cluding 24-hour mobile crisis teams, emer-

1 agency crisis intervention services, and cri-
2 sis stabilization.

3 (ii) Screening, assessment, and diag-
4 nosis, including risk assessment.

5 (iii) Patient-centered treatment plan-
6 ning or similar processes, including risk as-
7 sessment and crisis planning.

8 (iv) Outpatient mental health and
9 substance use services.

10 (v) Outpatient clinic primary care
11 screening and monitoring of key health in-
12 dicators and health risk.

13 (vi) Targeted case management.

14 (vii) Psychiatric rehabilitation serv-
15 ices.

16 (viii) Peer support and counselor serv-
17 ices and family supports.

18 (ix) Intensive, community-based men-
19 tal health care for members of the armed
20 forces and veterans, particularly those
21 members and veterans located in rural
22 areas, provided the care is consistent with
23 minimum clinical mental health guidelines
24 promulgated by the Veterans Health Ad-
25 ministration including clinical guidelines

1 contained in the Uniform Mental Health
2 Services Handbook of such Administration.

3 (E) QUALITY AND OTHER REPORTING.—

4 Reporting of encounter data, clinical outcomes
5 data, quality data, and such other data as the
6 Secretary requires.

7 (F) ORGANIZATIONAL AUTHORITY.—Cri-
8 teria that a clinic be a non-profit or part of a
9 local government behavioral health authority or
10 operated under the authority of the Indian
11 Health Service, an Indian tribe or tribal organi-
12 zation pursuant to a contract, grant, coopera-
13 tive agreement, or compact with the Indian
14 Health Service pursuant to the Indian Self-De-
15 termination Act (25 U.S.C. 450 et seq.), or an
16 urban Indian organization pursuant to a grant
17 or contract with the Indian Health Service
18 under title V of the Indian Health Care Im-
19 provement Act (25 U.S.C. 1601 et seq.).

20 (b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE
21 PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-
22 TION PROGRAMS.—

23 (1) IN GENERAL.—Not later than September 1,
24 2015, the Secretary, through the Administrator of
25 the Centers for Medicare & Medicaid Services, shall

1 issue guidance for the establishment of a prospective
2 payment system that shall only apply to medical as-
3 sistance for mental health services furnished by a
4 certified community behavioral health clinic partici-
5 pating in a demonstration program under subsection
6 (d).

7 (2) REQUIREMENTS.—The guidance issued by
8 the Secretary under paragraph (1) shall provide
9 that—

10 (A) no payment shall be made for inpatient
11 care, residential treatment, room and board ex-
12 penses, or any other non-ambulatory services,
13 as determined by the Secretary; and

14 (B) no payment shall be made to satellite
15 facilities of certified community behavioral
16 health clinics if such facilities are established
17 after the date of enactment of this Act.

18 (c) PLANNING GRANTS.—

19 (1) IN GENERAL.—Not later than January 1,
20 2016, the Secretary shall award planning grants to
21 States for the purpose of developing proposals to
22 participate in time-limited demonstration programs
23 described in subsection (d).

24 (2) USE OF FUNDS.—A State awarded a plan-
25 ning grant under this subsection shall—

1 (A) solicit input with respect to the devel-
2 opment of such a demonstration program from
3 patients, providers, and other stakeholders;

4 (B) certify clinics as certified community
5 behavioral health clinics for purposes of partici-
6 pating in a demonstration program conducted
7 under subsection (d); and

8 (C) establish a prospective payment system
9 for mental health services furnished by a cer-
10 tified community behavioral health clinic par-
11 ticipating in a demonstration program under
12 subsection (d) in accordance with the guidance
13 issued under subsection (b).

14 (d) DEMONSTRATION PROGRAMS.—

15 (1) IN GENERAL.—Not later than September 1,
16 2017, the Secretary shall select States to participate
17 in demonstration programs that are developed
18 through planning grants awarded under subsection
19 (c), meet the requirements of this subsection, and
20 represent a diverse selection of geographic areas, in-
21 cluding rural and underserved areas.

22 (2) APPLICATION REQUIREMENTS.—

23 (A) IN GENERAL.—The Secretary shall so-
24 licit applications to participate in demonstration
25 programs under this subsection solely from

1 States awarded planning grants under sub-
2 section (c).

3 (B) REQUIRED INFORMATION.—An appli-
4 cation for a demonstration program under this
5 subsection shall include the following:

6 (i) The target Medicaid population to
7 be served under the demonstration pro-
8 gram.

9 (ii) A list of participating certified
10 community behavioral health clinics.

11 (iii) Verification that the State has
12 certified a participating clinic as a certified
13 community behavioral health clinic in ac-
14 cordance with the requirements of sub-
15 section (b).

16 (iv) A description of the scope of the
17 mental health services available under the
18 State Medicaid program that will be paid
19 for under the prospective payment system
20 tested in the demonstration program.

21 (v) Verification that the State has
22 agreed to pay for such services at the rate
23 established under the prospective payment
24 system.

1 (vi) Such other information as the
2 Secretary may require relating to the dem-
3 onstration program including with respect
4 to determining the soundness of the pro-
5 posed prospective payment system.

6 (3) NUMBER AND LENGTH OF DEMONSTRATION
7 PROGRAMS.—Not more than 8 States shall be se-
8 lected for 4-year demonstration programs under this
9 subsection.

10 (4) REQUIREMENTS FOR SELECTING DEM-
11 ONSTRATION PROGRAMS.—

12 (A) IN GENERAL.—The Secretary shall
13 give preference to selecting demonstration pro-
14 grams where participating certified community
15 behavioral health clinics—

16 (i) provide the most complete scope of
17 services described in subsection (a)(2)(D)
18 to individuals eligible for medical assist-
19 ance under the State Medicaid program;

20 (ii) will improve availability of, access
21 to, and participation in, services described
22 in subsection (a)(2)(D) to individuals eligi-
23 ble for medical assistance under the State
24 Medicaid program;

1 (iii) will improve availability of, access
2 to, and participation in assisted outpatient
3 mental health treatment in the State; or

4 (iv) demonstrate the potential to ex-
5 pand available mental health services in a
6 demonstration area and increase the qual-
7 ity of such services without increasing net
8 Federal spending.

9 (5) PAYMENT FOR MEDICAL ASSISTANCE FOR
10 MENTAL HEALTH SERVICES PROVIDED BY CER-
11 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-
12 ICS.—

13 (A) IN GENERAL.—The Secretary shall pay
14 a State participating in a demonstration pro-
15 gram under this subsection the Federal match-
16 ing percentage specified in subparagraph (B)
17 for amounts expended by the State to provide
18 medical assistance for mental health services
19 described in the demonstration program appli-
20 cation in accordance with paragraph (2)(B)(iv)
21 that are provided by certified community behav-
22 ioral health clinics to individuals who are en-
23 rolled in the State Medicaid program. Payments
24 to States made under this paragraph shall be
25 considered to have been under, and are subject

1 to the requirements of, section 1903 of the So-
2 cial Security Act (42 U.S.C. 1396b).

3 (B) FEDERAL MATCHING PERCENTAGE.—

4 The Federal matching percentage specified in
5 this subparagraph is with respect to medical as-
6 sistance described in subparagraph (A) that is
7 furnished—

8 (i) to a newly eligible individual de-
9 scribed in paragraph (2) of section 1905(y)
10 of the Social Security Act (42 U.S.C.
11 1396d(y)), the matching rate applicable
12 under paragraph (1) of that section; and

13 (ii) to an individual who is not a
14 newly eligible individual (as so described)
15 but who is eligible for medical assistance
16 under the State Medicaid program, the en-
17 hanced FMAP applicable to the State.

18 (C) LIMITATIONS.—

19 (i) IN GENERAL.—Payments shall be
20 made under this paragraph to a State only
21 for mental health services—

22 (I) that are described in the dem-
23 onstration program application in ac-
24 cordance with paragraph (2)(B)(iv);

1 (II) for which payment is avail-
2 able under the State Medicaid pro-
3 gram; and

4 (III) that are provided to an indi-
5 vidual who is eligible for medical as-
6 sistance under the State Medicaid
7 program.

8 (ii) PROHIBITED PAYMENTS.—No
9 payment shall be made under this para-
10 graph—

11 (I) for inpatient care, residential
12 treatment, room and board expenses,
13 or any other non-ambulatory services,
14 as determined by the Secretary; or

15 (II) with respect to payments
16 made to satellite facilities of certified
17 community behavioral health clinics if
18 such facilities are established after the
19 date of enactment of this Act.

20 (6) WAIVER OF STATEWIDENESS REQUIRE-
21 MENT.—The Secretary shall waive section
22 1902(a)(1) of the Social Security Act (42 U.S.C.
23 1396a(a)(1)) (relating to statewideness) as may be
24 necessary to conduct demonstration programs in ac-
25 cordance with the requirements of this subsection.

1 (7) ANNUAL REPORTS.—

2 (A) IN GENERAL.—Not later than 1 year
3 after the date on which the first State is se-
4 lected for a demonstration program under this
5 subsection, and annually thereafter, the Sec-
6 retary shall submit to Congress an annual re-
7 port on the use of funds provided under all
8 demonstration programs conducted under this
9 subsection. Each such report shall include—

10 (i) an assessment of access to commu-
11 nity-based mental health services under the
12 Medicaid program in the area or areas of
13 a State targeted by a demonstration pro-
14 gram compared to other areas of the State;

15 (ii) an assessment of the quality and
16 scope of services provided by certified com-
17 munity behavioral health clinics compared
18 to community-based mental health services
19 provided in States not participating in a
20 demonstration program under this sub-
21 section and in areas of a demonstration
22 State that are not participating in the
23 demonstration program; and

24 (iii) an assessment of the impact of
25 the demonstration programs on the Fed-

1 eral and State costs of a full range of men-
2 tal health services (including inpatient,
3 emergency and ambulatory services).

4 (B) RECOMMENDATIONS.—Not later than
5 December 31, 2021, the Secretary shall submit
6 to Congress recommendations concerning
7 whether the demonstration programs under this
8 section should be continued, expanded, modi-
9 fied, or terminated.

10 (e) DEFINITIONS.—In this section:

11 (1) FEDERALLY-QUALIFIED HEALTH CENTER
12 SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER;
13 RURAL HEALTH CLINIC SERVICES; RURAL HEALTH
14 CLINIC.—The terms “Federally-qualified health cen-
15 ter services”, “Federally-qualified health center”,
16 “rural health clinic services”, and “rural health clin-
17 ic” have the meanings given those terms in section
18 1905(l) of the Social Security Act (42 U.S.C.
19 1396d(l)).

20 (2) ENHANCED FMAP.—The term “enhanced
21 FMAP” has the meaning given that term in section
22 2105(b) of the Social Security Act (42 U.S.C.
23 1397dd(b) but without regard to the second and
24 third sentences of that section.

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

3 (4) STATE.—The term “State” has the mean-
4 ing given such term for purposes of title XIX of the
5 Social Security Act (42 U.S.C. 1396 et seq.).

6 (f) FUNDING.—

7 (1) IN GENERAL.—Out of any funds in the
8 Treasury not otherwise appropriated, there is appro-
9 priated to the Secretary—

10 (A) for purposes of carrying out sub-
11 sections (a), (b), and (d)(7), \$2,000,000 for fis-
12 cal year 2014; and

13 (B) for purposes of awarding planning
14 grants under subsection (c), \$25,000,000 for
15 fiscal year 2016.

16 (2) AVAILABILITY.—Funds appropriated under
17 paragraph (1) shall remain available until expended.

18 **SEC. 416. ANNUAL MEDICAID DSH REPORT.**

19 Section 1923 of the Social Security Act (42 U.S.C.
20 1396r-4) is amended by adding at the end the following:

21 “(k) ANNUAL REPORT TO CONGRESS.—

22 “(1) IN GENERAL.—Beginning January 1,
23 2015, and annually thereafter, the Secretary shall
24 submit a report to Congress on the program estab-
25 lished under this section for making payment adjust-

1 ments to disproportionate share hospitals for the
2 purpose of providing Congress with information rel-
3 evant to determining an appropriate level of overall
4 funding for such payment adjustments during and
5 after the period in which aggregate reductions in the
6 DSH allotments to States are required under para-
7 graphs (7) and (8) of subsection (f).

8 “(2) REQUIRED REPORT INFORMATION.—Ex-
9 cept as otherwise provided, each report submitted
10 under this subsection shall include the following:

11 “(A) Information and data relating to
12 changes in the number of uninsured individuals
13 for the most recent year for which such data
14 are available as compared to 2013 and as com-
15 pared to the Congressional Budget Office esti-
16 mates of uninsured individuals made at the
17 time of the enactment of the Patient Protection
18 and Affordable Care Act (Public Law 111–148)
19 and the Health Care and Education Reconcili-
20 ation Act of 2010 (Public Law 111–152).

21 “(B) Information and data relating to the
22 extent to which hospitals continue to incur un-
23 compensated care costs from providing unreim-
24 bursed or under-reimbursed services to individ-
25 uals who either are eligible for medical assist-

1 ance under the State plan under this title or
2 under a waiver of such plan or who have no
3 health insurance (or other source of third party
4 coverage) for such services.

5 “(C) Information and data relating to the
6 extent to which hospitals continue to provide
7 charity care and unreimbursed or under-reim-
8 bursed services, or otherwise incur bad debt,
9 under the program established under this title,
10 the State Children’s Health Insurance Program
11 established under title XXI, and State or local
12 indigent care programs, as reported on cost re-
13 ports submitted under title XVIII or such other
14 data as the Secretary determines appropriate.

15 “(D) In the first report submitted under
16 this section, a methodology for estimating the
17 amount of unpaid patient deductibles, copay-
18 ments and coinsurance incurred by hospitals for
19 patients enrolled in qualified health plans
20 through an American Health Benefits Ex-
21 change, using existing data and minimizing the
22 administrative burden on hospitals to the extent
23 possible, and in subsequent reports, data re-
24 garding such uncompensated care costs col-
25 lected pursuant to such methodology.

1 “(E) For each State, information and data
2 relating to the difference between the DSH al-
3 lotment for the State for the fiscal year that
4 began on October 1 of the year preceding the
5 year in which the report is submitted and the
6 aggregate amount of uncompensated care costs
7 for all disproportionate share hospitals in the
8 State.

9 “(F) Information and data relating to the
10 extent to which there are certain vital hospital
11 systems that are disproportionately experiencing
12 high levels of uncompensated care and that
13 have multiple other missions, such as a commit-
14 ment to graduate medical education, the provi-
15 sion of tertiary and trauma care services, pro-
16 viding public health and essential community
17 services, and providing comprehensive, coordi-
18 nated care.

19 “(G) Such other information and data rel-
20 evant to the determination of the level of fund-
21 ing for, and amount of, State DSH allotments
22 as the Secretary determines appropriate

23 “(3) AUTHORIZATION OF APPROPRIATIONS.—

24 There is authorized to be appropriated to the Sec-
25 retary for the period of fiscal years 2015 through

1 2109, such sums as may be necessary to carry out
2 this subsection.”.

3 **SEC. 417. IMPLEMENTATION.**

4 To the extent the Secretary of Health and Human
5 Services issues a regulation to carry out the provisions of
6 this Act, the Secretary shall, unless otherwise specified in
7 this Act—

8 (1) issue a notice of proposed rulemaking that
9 includes the proposed regulation;

10 (2) provide a period of not less than 60 cal-
11 endar days for comments on the proposed regula-
12 tion;

13 (3) not more than 24 months following the date
14 of publication of the proposed rule, publish the final
15 regulation or take alternative action (such as with-
16 drawing the rule or proposing a revised rule with a
17 new comment period) on the proposed regulation;
18 and

19 (4) not less than 30 days before the effective
20 date of the final regulation, publish the final regula-
21 tion or take alternative action (such as withdrawing
22 the rule or proposing a revised rule with a new com-
23 ment period) on the proposed regulation.

Calendar No. 327

113TH CONGRESS
2^D SESSION

S. 2110

A BILL

To amend titles XVIII and XIX of the Social Security Act to repeal the Medicare sustainable growth rate and to improve Medicare and Medicaid payments, and for other purposes.

MARCH 12, 2014

Read the second time and placed on the calendar