

# Calendar No. 327

113<sup>TH</sup> CONGRESS  
2<sup>D</sup> 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.

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## 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

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## 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 Tially 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           ually 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           scripture 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)”; and

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”; 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 (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           onstration 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 under part B of title XVIII of such Act (42  
2 U.S.C. 1395j et seq.), and is eligible for medical  
3 assistance under a State plan under title XIX  
4 of such Act (42 U.S.C. 1396 et seq.) or under  
5 a waiver of such plan.

## 6 **TITLE IV—OTHER PROVISIONS**

### 7 **SEC. 401. COMMISSION ON IMPROVING PATIENT DIRECTED** 8 **HEALTH CARE.**

9 (a) FINDINGS.—Congress finds the following:

10 (1) In order to elevate the role of patient  
11 choices in the health care system, the American pub-  
12 lic must engage in an informed, national, public de-  
13 bate on how the current health care system empow-  
14 ers and informs health care decision-making, and  
15 what can be done to improve the likelihood patients  
16 receive the care they want and need.

17 (2) Research suggests that patients often do  
18 not receive the care they want. As a result, the end  
19 of life is associated with a substantial burden of suf-  
20 fering by the patient and negative health and finan-  
21 cial consequences that extend to family members and  
22 society.

23 (3) Patients face a complex and fragmented  
24 health care system that may decrease the likelihood  
25 that health care choices are known and carried out.



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

113<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**S. 2110**

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**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.

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MARCH 12, 2014

Read the second time and placed on the calendar