(a) the competitiveness of the health market in the States in which such plans operate, including whether those States maintain certificate-of-need laws or other anti-competitive restrictions on health access; and

(b) the enhanced access to health outcomes made possible through telehealth services or other innovative technologies.

SEC. 5. *Enabling Providers to Spend More Time with Patients*. Within 1 year of the date of this order, the Secretary shall propose reforms to the Medicare program to enable providers to spend more time with patients by:

(a) proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession;

(b) proposing a regulation that would ensure appropriate reimbursement by Medicare for time spent with patients by both primary and specialist health providers practicing in all types of health professions; and

(c) conducting a comprehensive review of regulatory policies that create disparities in reimbursement between physicians and non-physician practitioners and proposing a regulation that would, to the extent allowed by law, ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician's occupation.

SEC. 6. *Encouraging Innovation for Patients*. Within 1 year of the date of this order, the Secretary shall propose regulatory and sub-regulatory changes to the Medicare program to encourage innovation for patients by:

(a) streamlining the approval, coverage, and coding process so that innovative products are brought to market faster, and so that such products, including breakthrough medical devices and advances in telehealth services and similar technologies, are appropriately reimbursed and widely available, consistent with the principles of patient safety, market-based policies, and value for patients. This process shall include:

(i) adopting regulations and guidance that minimize and eliminate, as appropriate, the time and steps between approval by the Food and Drug Administration (FDA) and coverage decisions by the Centers for Medicare and Medicaid Services (CMS);

(ii) clarifying the application of coverage standards, including the evidence standards CMS uses in applying its reasonable-and-necessary standard, the standards for deciding appeals of coverage decisions, and the prioritization and timeline for each National Coverage Determination process in light of changes made to local coverage determination processes; and

(iii) identifying challenges to the use of parallel FDA and CMS review and proposing changes to address those challenges; and

(b) modifying the Value-Based Insurance Design payment model to remove any disincentives for MA plans to cover items and services that make use of new technologies that are not covered by FFS Medicare when those items and services can save money and improve the quality of care.

SEC. 7. *Rewarding Care Through Site Neutrality*. The Secretary shall ensure that Medicare payments and policies encourage competition and a diversity of sites for patients to access care.

SEC. 8. *Empowering Patients, Caregivers, and Health Providers*. (a) Within 1 year of the date of this order, the Secretary shall propose a regulation that would provide seniors with better quality care and cost data, improving their ability to make decisions about their healthcare that work best for them and to hold providers and plans accountable.

(b) Within 1 year of the date of this order, the Secretary shall use Medicare claims data to give health providers additional information regarding practice patterns for services that may pose undue risks to patients, and to inform health providers about practice patterns that are outliers or that are outside recommended standards of care.

SEC. 9. *Eliminating Waste, Fraud, and Abuse to Protect Beneficiaries and Taxpayers*. (a) The Secretary shall propose regulatory or sub-regulatory changes to the Medicare program, to take effect by January 1, 2021, and shall propose such changes annually thereafter, to combat fraud, waste, and abuse in the Medicare program. The Secretary shall undertake all appropriate efforts to direct public and private resources toward detecting and preventing fraud, waste, and abuse, including through the use of the latest technologies such as artificial intelligence.

(b) The Secretary shall study and, within 180 days of the date of this order, recommend approaches to transition toward true market-based pricing in the FFS Medicare program. The Secretary shall submit the results of this study to the President through the Assistants to the President for Domestic and Economic Policy. Approaches studied shall include:

(i) shared savings and competitive bidding in FFS Medicare;

(ii) use of MA-negotiated rates to set FFS Medicare rates; and

(iii) novel approaches to information development and sharing that may enable markets to lower cost and improve quality for FFS Medicare beneficiaries.

SEC. 10. *Reducing Obstacles to Improved Patient Care*. Within 1 year of the date of this order, the Secretary shall propose regulatory changes to the Medicare program to reduce the burden on providers and eliminate regulations that create inefficiencies or otherwise undermine patient outcomes.

SEC. 11. *Maximizing Freedom for Medicare Patients and Providers*. (a) Within 180 days of the date of this order, the Secretary, in coordination with the Commissioner of Social Security, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A, and propose other administrative improvements to Medicare enrollment processes for beneficiaries.

(b) Within 1 year of the date of this order, the Secretary shall identify and remove unnecessary barriers to private contracts that allow Medicare beneficiaries to obtain the care of their choice and facilitate the development of market-driven prices.

SEC. 12. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

§ 1395. Prohibition against any Federal interference

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or

operation of any such institution, agency, or person.

(Aug. 14, 1935, ch. 531, title XVIII, § 1801, as added Pub. L. 89–97, title I, § 102(a), July 30, 1965, 79 Stat. 291.)

SHORT TITLE

For short title of title I of Pub. L. 89–97, which enacted this subchapter as the ''Health Insurance for the Aged Act'', see section 100 of Pub. L. 89–97, set out as a Short Title of 1965 Amendment note under section 1305 of this title.

PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS

Pub. L. 111–148, title III, § 3601, Mar. 23, 2010, 124 Stat. 538, provided that:

''(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act [see Short Title note set out under section 18001 of this title] shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

''(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.''

§ 1395a. Free choice by patient guaranteed

(a) Basic freedom of choice

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

(b) Use of private contracts by medicare beneficiaries

(1) In general

Subject to the provisions of this subsection, nothing in this subchapter shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

(A) for which no claim for payment is to be submitted under this subchapter, and

(B) for which the physician or practitioner receives—

(i) no reimbursement under this subchapter directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this subchapter directly or on a capitated basis.

(2) Beneficiary protections

(A) In general

Paragraph (1) shall not apply to any contract unless—

(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

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

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

(B) Items required to be included in contract

Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this subchapter for such items or services even if such items or services are otherwise covered by this subchapter;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this subchapter for such items or services;

(iii) acknowledges that no limits under this subchapter (including the limits under section 1395w–4(g) of this title) apply to amounts that may be charged for such items or services;

(iv) acknowledges that Medigap plans under section 1395ss of this title do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this subchapter; and

(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this subchapter.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1320a–7 of this title.

(3) Physician or practitioner requirements

(A) In general

Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

(B) Affidavit

An affidavit is described in this subparagraph if—

(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

(ii) the affidavit provides that the physician or practitioner will not submit any claim under this subchapter for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the applicable 2-year period (as defined in subparagraph (D)); and

(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.