Calendar No. 327

113TH CONGRESS
2D 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.

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

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

(a) SHORT TITLE.—This Act may be cited as the ''Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014''.

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

# TITLE I—MEDICARE PAYMENT FOR PHYSICIANS' SERVICES

## SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

(a) STABILIZING FEE UPDATES.—

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

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting ''or a subsequent paragraph'' after ''paragraph (4)''; and

(ii) in paragraph (4)—

(I) in the heading, by inserting ''AND ENDING WITH 2013'' after ''YEARS BEGINNING WITH 2001''; and

(II) in subparagraph (A), by inserting ''and ending with 2013'' after ''a year beginning with 2001''; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting ''through 2013'' after ''of each succeeding year''; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''and ending with 2013'' after ''beginning with 2000''.

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

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

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

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

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

''(A) for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) for such year, 1.0 percent; and

''(B) for other items and services, 0.5 percent.''.

(3) MEDPAC REPORTS.—

(A) INITIAL REPORT.—Not later than July 1, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment is made under section 1848 of the Social Security Act (42 U.S.C. 1395w–4); and

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

Such report shall include a methodology to describe such relationship and the impact of changes in such physician and other health professional practice and service ordering patterns on total utilization and expenditures under parts A, B, and D of such title.

(B) FINAL REPORT.—Not later than July 1, 2020, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship described in subparagraph (A), including the results determined from applying the methodology included in the report submitted under such subparagraph.

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

(i) the payment update for professional services applied under the Medicare program under title XVIII of the Social Security Act for the period of years 2014 through 2018;

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

(iii) the effect of such update on ensuring a sufficient number of providers to maintain access to care by Medicare beneficiaries; and

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

(b) CONSOLIDATION OF CERTAIN CURRENT LAW PERFORMANCE PROGRAMS WITH NEW MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

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

(i) in clause (i), by striking ''2015 or any subsequent payment year'' and inserting ''2015, 2016, or 2017'';

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by striking ''Subject to clause (iii), for'' and inserting ''For''; and

(II) in subclause (III), by striking ''and each subsequent year''; and

(iii) by striking clause (iii).

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

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

(I) by striking ''For purposes of paragraph (1), an'' and inserting ''An''; and

(II) by inserting '', or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year'' after ''under such subsection for a year''; and

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

''(D) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—With respect to 2018 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.''.

(2) QUALITY REPORTING.—

(A) SUNSETTING SEPARATE QUALITY REPORTING INCENTIVES.—Section 1848(a)(8)(A)

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

(i) in clause (i), by striking ''2015 or any subsequent year'' and inserting ''2015, 2016, or 2017''; and

(ii) in clause (ii)(II), by striking ''and each subsequent year'' and inserting ''and 2017''.

(B) CONTINUATION OF QUALITY MEASURES AND PROCESSES FOR MIPS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

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

''(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

''(A) for purposes of subsection (q); and

''(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.''; and

(ii) in subsection (m)—

(I) by redesignating paragraph (7) added by section 10327(a) of Public Law 111–148 as paragraph (8); and

(II) by adding at the end the following new paragraph:

''(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

''(A) for purposes of subsection (q); and

''(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.''.

(3) VALUE-BASED PAYMENTS.—

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

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1,

2015, but before January 1, 2018, with respect to specific physicians and groups of physicians the Secretary determines appropriate. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2018.''.

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

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

''(C) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).''; and

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

(c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

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

''(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish an eligible professional Merit-based Incentive Payment System (in this subsection referred to as the 'MIPS') under which the Secretary shall—

''(i) develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) for a performance period (as established under paragraph (4)) for a year;

''(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

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

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

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

''(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iv), the term 'MIPS eligible professional' means—

''(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)) and a

group that includes such professionals; and

''(II) for the third year for which the MIPS applies to payments (and for the performance period for such third year) and for each succeeding year (and for the performance period for each such year), the professionals described in subclause (I) and such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary and a group that includes such professionals.

''(ii) EXCLUSIONS.—For purposes of clause (i), the term 'MIPS eligible professional' does not include, with respect to a year, an eligible professional (as defined in subsection (k)(3)(B)) who—

''(I) is a qualifying APM participant (as defined in section 1833(z)(2));

''(II) subject to clause (vii), is a partial qualifying APM participant (as defined in clause (iii)) for the most recent period for which data are avail-

able and who, for the performance period with respect to such year, does not report on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS; or

''(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

''(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term 'partial qualifying APM participant' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

''(I) with respect to 2018 and 2019, the reference in subparagraph

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

"(II) with respect to 2020 and 2021—

"(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

"(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

"(III) with respect to 2022 and subsequent years—

"(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

"(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were in-

stead references to 50 percent and 20 percent, respectively.

''(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

''(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

''(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

''(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

''(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In

the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

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

''(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

''(I) TREATMENT AS MIPS ELIGIBLE PROFESSIONAL.—In the case of

an eligible professional who is a partial qualifying APM participant, with respect to a year, and who for the performance period for such year reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

''(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

''(D) APPLICATION TO GROUP PRACTICES.—

''(i) IN GENERAL.—Under the MIPS:

"(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

"(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

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

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

"(iii) CLARIFICATION.—MIPS eligible professionals electing to be a virtual group under paragraph (5)(I) shall not be considered MIPS eligible professionals in a group practice for purposes of applying this subparagraph.

"(E) USE OF REGISTRIES.—Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

"(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

"(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

"(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

"(G) ACCOUNTING FOR RISK FACTORS.—

"(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 101(f)(1) of the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014, the Secretary, on an ongoing basis, shall estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into the MIPS.

"(ii) ACCOUNTING FOR OTHER FACTORS IN PAYMENT ADJUSTMENTS.—Taking into account the studies conducted and recommendations made in reports under section 101(f)(1) of the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014 and other information as appropriate, the Secretary shall account for identified factors with an effect on quality and resource use outcome measures when determining payment adjustments, com-

posite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

''(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

''(A) PERFORMANCE CATEGORIES.—Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

''(i) Quality.

''(ii) Resource use.

''(iii) Clinical practice improvement activities.

''(iv) Meaningful use of certified EHR technology.

''(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

''(i) QUALITY.—For the performance category described in subparagraph (A)(i),

the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

''(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

''(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

''(I) The subcategory of expanded practice access, which shall include activities such as same day appoint-

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

''(II) The subcategory of population management, which shall include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

''(III) The subcategory of care coordination, which shall include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

''(IV) The subcategory of beneficiary engagement, which shall include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

"(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

"(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

"(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

"(C) ADDITIONAL PROVISIONS.—

"(i) EMPHASIZING OUTCOME MEASURES UNDER THE QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

"(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of emergency physicians.

"(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

"(iv) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PRO-

FESSIONALS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

"(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

"(II) may, to the extent feasible and appropriate, take into account such circumstances and apply under this subsection with respect to MIPS eligible professionals of such professional types or subcategories, alternative measures or activities that fulfill the goals of the applicable performance category.

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

"(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

"(I) REQUEST FOR INFORMATION.—In initially applying subparagraph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

"(II) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

"(aa) identifying activities described in subparagraph (B)(iii);

"(bb) specifying criteria for such activities; and

"(cc) determining whether a MIPS eligible professional meets such criteria.

"(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

"(D) ANNUAL LIST OF QUALITY MEASURES AVAILABLE FOR MIPS ASSESSMENT.—

"(i) IN GENERAL.—Under the MIPS, the Secretary, through notice and comment rulemaking and subject to the succeeding clauses of this subparagraph, shall, with respect to the performance period for a year, establish an annual final list of quality measures from which MIPS eligible professionals may choose for purposes of assessment under this subsection for such performance period. Pursuant to the previous sentence, the Secretary shall—

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

"(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

"(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

"(bb) adding to such list, as appropriate, new quality measures; and

"(cc) determining whether or not quality measures on such list that have undergone sub-

stantive changes should be included in the updated list.

"(ii) CALL FOR QUALITY MEASURES.—

"(I) IN GENERAL.—Eligible professional organizations and other relevant stakeholders shall be requested to identify and submit quality measures to be considered for selection under this subparagraph in the annual list of quality measures published under clause (i) and to identify and submit updates to the measures on such list. For purposes of the previous sentence, measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by an entity with a contract under section 1890(a).

"(II) ELIGIBLE PROFESSIONAL ORGANIZATION DEFINED.—In this subparagraph, the term 'eligible professional organization' means a professional organization as defined by nationally recognized multispecialty

boards of certification or equivalent certification boards.

''(iii) REQUIREMENTS.—In selecting quality measures for inclusion in the annual final list under clause (i), the Secretary shall—

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

''(II) ensure that such selection is consistent with the process for selection of measures under subsections (k), (m), and (p)(2).

''(iv) PEER REVIEW.—Before including a new measure or a measure described in clause (i)(II)(cc) in the final list of measures published under clause (i) for a year, the Secretary shall submit for publication in applicable specialty-appropriate peer-reviewed journals such measure and the method for developing and selecting such measure, including clinical and other data supporting such measure.

"(v) MEASURES FOR INCLUSION.—The final list of quality measures published under clause (i) shall include, as applicable, measures under subsections (k), (m), and (p)(2), including quality measures from among—

"(I) measures endorsed by a consensus-based entity;

"(II) measures developed under subsection (s); and

"(III) measures submitted under clause (ii)(I).

Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity shall have a focus that is evidence-based.

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

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

''(vii) EXCEPTION FOR EXISTING QUALITY MEASURES.—Any quality measure specified by the Secretary under subsection (k) or (m), including under subsection (m)(3)(E), and any measure of quality of care established under subsection (p)(2) for the reporting period under the respective subsection beginning before the first performance period under the MIPS—

''(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

''(II) shall be included in the final list of quality measures published under clause (i) unless removed under clause (i)(II)(aa).

''(viii) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional

organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

''(ix) OPTIONAL APPLICATION.—The process under section 1890A is not required to apply to the selection of measures under this subparagraph.

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

''(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

''(i) Historical performance standards.

''(ii) Improvement.

''(iii) The opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with the year described in paragraph (1)(B)). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

''(5) COMPOSITE PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for

the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the 'composite performance score' for such professional for such performance period.

''(B) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

''(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

''(ii) ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY AND QUALIFIED CLINICAL DATA REGISTRIES FOR REPORTING QUALITY MEASURES.—Under the methodology established under subparagraph (A), the Secretary shall—

"(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

"(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

"(C) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE SCORE.—

"(i) RULE FOR ACCREDITATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice pursuant to subsection (b)(8)(B)(i) with respect to a performance period shall be given the highest potential

score for the performance category described in paragraph (2)(A)(iii) for such period.

''(ii) APM PARTICIPATION.—Participation by a MIPS eligible professional in an alternative payment model (as defined in section 1833(z)(3)(C)) with respect to a performance period shall earn such eligible professional a minimum score of one-half of the highest potential score for the performance category described in paragraph (2)(A)(iii) for such performance period.

''(iii) SUBCATEGORIES.—A MIPS eligible professional shall not be required to perform activities in each subcategory under paragraph (2)(B)(iii) or participate in an alternative payment model in order to achieve the highest potential score for the performance category described in paragraph (2)(A)(iii).

''(D) ACHIEVEMENT AND IMPROVEMENT.—

''(i) TAKING INTO ACCOUNT IMPROVEMENT.—Beginning with the second year to which the MIPS applies, in addition to the

achievement of a MIPS eligible professional, if data sufficient to measure improvement is available, the methodology developed under subparagraph (A)—

"(I) in the case of the performance score for the performance category described in clauses (i) and (ii) of paragraph (2)(A), shall take into account the improvement of the professional; and

"(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

"(ii) ASSIGNING HIGHER WEIGHT FOR ACHIEVEMENT.—Beginning with the fourth year to which the MIPS applies, under the methodology developed under subparagraph (A), the Secretary may assign a higher scoring weight under subparagraph (F) with respect to the achievement of a MIPS eligible professional than with respect to any improvement of such professional applied under clause (i) with

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

''(E) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

''(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clauses (ii) and (iii), the composite performance score shall be determined as follows:

''(I) QUALITY.—

''(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (i) of paragraph (2)(A). In applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

''(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be in-

creased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

''(II) RESOURCE USE.—

''(aa) IN GENERAL.—Subject to item (bb), thirty percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

''(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year for which the MIPS applies

to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

''(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—Fifteen percent of such score shall be based on performance with respect to the category described in clause (iii) of paragraph (2)(A).

''(IV) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—Twenty-five percent of such score shall be based on performance with respect to the category described in clause (iv) of paragraph (2)(A).

''(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the

Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

''(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and clinical practice improvement activities applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

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

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

"(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

"(G) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

"(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

''(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

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

''(I) the assessment of performance provided under such methodology with respect to the performance categories described in clauses (i) and (ii) of paragraph (2)(A) that is to be applied to each such professional in such group for such performance period shall be with respect to the combined performance of all such professionals in such group for such period; and

''(II) the composite score provided under this paragraph for such performance period with respect to each such performance category for each such MIPS eligible professional in such virtual group shall be based

on the assessment of the combined performance under subclause (I) for the performance category and performance period.

''(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year, for such individual MIPS eligible professional or all such MIPS eligible professionals in such group practice, respectively, to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice making such an election. Such a virtual group may be based on geographic areas or on provider specialties defined by nationally recognized multispecialty boards of certification or equivalent certification boards and such other eligible professional groupings in order to capture classifica-

tions of providers across eligible professional organizations and other practice areas or categories.

''(iii) REQUIREMENTS.—The process under clause (ii)—

''(I) shall provide that an election under such clause, with respect to a performance period, shall be made before or during the beginning of such performance period and may not be changed during such performance period;

''(II) shall provide that a practice described in such clause, and each MIPS eligible professional in such practice, may elect to be in no more than one virtual group for a performance period; and

''(III) may provide that a virtual group may be combined at the tax identification number level.

''(6) MIPS PAYMENTS.—

''(A) MIPS ADJUSTMENT FACTOR.—Taking into account paragraph (1)(G), the Secretary shall specify a MIPS adjustment factor

for each MIPS eligible professional for a year. Such MIPS adjustment factor for a MIPS eligible professional for a year shall be in the form of a percent and shall be determined—

"(i) by comparing the composite performance score of the eligible professional for such year to the performance threshold established under subparagraph (D)(i) for such year;

"(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

"(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive incentive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

"(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

"(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

"(iv) in a manner such that—

"(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in

clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

''(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

''(B) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

''(i) for 2018, 4 percent;

''(ii) for 2019, 5 percent;

''(iii) for 2020, 7 percent; and

"(iv) for 2021 and subsequent years, 9 percent.

"(C) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—

"(i) IN GENERAL.—In the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to the availability of funds under clause (ii), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

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

the Federal Supplementary Medical Insurance Trust Fund $500,000,000 for MIPS payments under this paragraph resulting from the application of the additional MIPS adjustment factors under clause (i).

''(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

''(i) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection under the previous sentence every 3 years.

''(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORM-

ANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C)(i). For each such year, the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

"(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold with respect to the prior period described in clause (i).

"(II) The threshold shall be the score that is equal to the 25th percentile of the actual composite performance scores for MIPS eligible professionals with composite performance scores at or above the performance threshold with respect to the prior period described in clause (i).

"(iii) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C)(i). Each such performance threshold shall—

"(I) be based on a period prior to such performance periods; and

"(II) take into account—

"(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

"(bb) other factors determined appropriate by the Secretary.

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

furnished by a MIPS eligible professional during a year (beginning with 2018), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

"(i) 1, plus

"(ii) the sum of—

"(I) the MIPS adjustment factor determined under subparagraph (A) divided by 100, and

"(II) as applicable, the additional MIPS adjustment factor determined under subparagraph (C)(i) divided by 100.

"(F) AGGREGATE APPLICATION OF MIPS ADJUSTMENT FACTORS.—

"(i) APPLICATION OF SCALING FACTOR.—

"(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to

subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

''(II) SCALING FACTOR LIMIT.—In no case may be the scaling factor applied under this clause exceed 3.0.

''(ii) BUDGET NEUTRALITY REQUIREMENT.—

''(I) IN GENERAL.—Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

''(II) AGGREGATE INCREASES.—The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose

composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

''(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

''(iii) EXCEPTIONS.—

''(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neu-

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

''(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

''(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—In specifying the MIPS additional adjustment factors under subparagraph (C)(i) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to the additional funding pool amount for such year under subparagraph (C)(ii).

''(7) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the MIPS, the Secretary shall, not

later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for items and services furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

''(8) NO EFFECT IN SUBSEQUENT YEARS.—The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

''(9) PUBLIC REPORTING.—

''(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

''(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

"(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

"(II) may include the performance of each such MIPS eligible professional with respect to each measure or activity specified in paragraph (2)(B).

"(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

"(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

"(C) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for a professional described in subparagraph (A) to review, and submit corrections for, the information to be made public with respect to the professional under such subparagraph prior to such information being made public.

"(D) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Physician Compare Internet website aggregate information on the MIPS, including the range of composite scores for all MIPS eligible professionals and the range of the performance of all MIPS eligible professionals with respect to each performance category.

"(10) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the MIPS, including for the identification of measures and activities under paragraph (2)(B) and the methodologies developed under paragraphs (5)(A) and (6) and regarding the use of qualified clinical data registries. Such consultation shall include the use of a request for information or other mechanisms determined appropriate.

''(11) TECHNICAL ASSISTANCE TO SMALL PRACTICES AND PRACTICES IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

''(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

''(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

''(B) FUNDING FOR IMPLEMENTATION.—

"(i) IN GENERAL.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $40,000,000 for each of fiscal years 2015 through 2019. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

"(ii) TECHNICAL ASSISTANCE.—Of the amounts transferred pursuant to clause (i) for each of fiscal years 2015 through 2019, not less than $10,000,000 shall be made available for each such year for technical assistance to small practices in health professional shortage areas (as so designated) and medically underserved areas.

"(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

"(A) PERFORMANCE FEEDBACK.—

"(i) IN GENERAL.—Beginning July 1, 2016, the Secretary—

''(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

''(II) may make available confidential feedback to each such professional on the performance of such professional with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

''(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k)

and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

''(iii) USE OF DATA.—For purposes of clause (i), the Secretary may use data, with respect to a MIPS eligible professional, from periods prior to the current performance period and may use rolling periods in order to make illustrative calculations about the performance of such professional.

''(iv) DISCLOSURE EXEMPTION.—Feedback made available under this subparagraph shall be exempt from disclosure under section 552 of title 5, United States Code.

''(v) RECEIPT OF INFORMATION.—The Secretary may use the mechanisms established under clause (ii) to receive infor-

mation from professionals, such as information with respect to this subsection.

''(B) ADDITIONAL INFORMATION.—

''(i) IN GENERAL.—Beginning July 1, 2017, the Secretary shall make available to each MIPS eligible professional information, with respect to individuals who are patients of such MIPS eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1899, including a beneficiary opt-out.

"(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

"(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

"(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

''(13) REVIEW.—

''(A) TARGETED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

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

''(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment

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

''(ii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

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

''(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.''.

(2) GAO REPORTS.—

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

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

(i) examine the distribution of the composite performance scores and MIPS adjustment factors (and additional MIPS adjustment factors) for MIPS eligible professionals (as defined in subsection (q)(1)(c) of such section) under such program, and patterns relating to such scores and adjustment factors, including based on type of provider, practice size, geographic location, and patient mix;

(ii) provide recommendations for improving such program;

(iii) evaluate the impact of technical assistance funding under section 1848(q)(11) of the Social Security Act, as added by paragraph (1), on the ability of professionals to improve within such program or successfully transition to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)), with priority for such evaluation given to practices lo-

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

(iv) provide recommendations for optimizing the use of such technical assistance funds.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—

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

(I) compares the similarities and differences in the use of quality measures under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, selected State Medicaid programs under title XIX of such Act, and private payer arrangements; and

(II) makes recommendations on how to reduce the administrative burden involved in applying such quality measures.

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

(I) consider those measures applicable to individuals entitled to, or enrolled for, benefits under such part A, or enrolled under such part B and individuals under the age of 65; and

(II) focus on those measures that comprise the most significant component of the quality performance category of the eligible professional MIPS incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1).

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

risk managers, can play a role in supporting physician practices, particularly small physician practices, in assuming financial risk for the treatment of patients. Such report shall examine barriers that small physician practices currently face in assuming financial risk for treating patients, the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could assist with risk management and with quality improvement activities. Such report shall also include an analysis of any existing legal barriers to such arrangements.

(D) STUDY TO EXAMINE RURAL AND HEALTH PROFESSIONAL SHORTAGE AREA ALTERNATIVE PAYMENT MODELS.—Not later than October 1, 2020, and October 1, 2022, the Comptroller General of the United States shall submit to Congress a report that examines the transition of professionals in rural areas, health professional shortage areas (as designated in section 332(a)(1)(A) of the Public Health Service Act), or medically underserved areas to an alternative payment model (as defined in sec-

tion 1833(z)(3) of the Social Security Act, as added by subsection (e)). Such report shall make recommendations for removing administrative barriers to practices, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas to participation in such models.

(3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of $80,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2014 through 2018. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

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

(B) CLARIFICATION OF QUALIFIED CLINICAL DATA REGISTRY REPORTING TO GROUP PRACTICES.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting ''and, for 2015 and subsequent years, subparagraph (A) or (C)'' after ''subparagraph (A)''.

(2) CHANGES FOR MULTIPLE REPORTING PERIODS AND ALTERNATIVE CRITERIA FOR SATISFACTORY REPORTING.—Section 1848(m)(5)(F) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)(F)) is amended—

(A) by striking ''and subsequent years'' and inserting ''through reporting periods occurring in 2014''; and

(B) by inserting ''and, for reporting periods occurring in 2015 and subsequent years, the Secretary may establish'' following ''shall establish''.

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

''(11) REPORTS ENDING WITH 2016.—Reports under the Program shall not be provided after December 31, 2016. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.''.

(4) COORDINATION WITH SATISFYING MEANINGFUL EHR USE CLINICAL QUALITY MEASURE REPORTING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(iii)) is amended by inserting ''and subsection (q)(5)(B)(ii)(II)'' after ''Subject to subparagraph (B)(ii)''.

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

''(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

''(1) TECHNICAL ADVISORY COMMITTEE.—

''(A) ESTABLISHMENT.—There is established an ad hoc committee to be known as the 'Payment Model Technical Advisory Committee' (referred to in this subsection as the 'Committee').

''(B) MEMBERSHIP.—

''(i) NUMBER AND APPOINTMENT.—The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

''(ii) QUALIFICATIONS.—The membership of the Committee shall include individuals with national recognition for their expertise in payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

''(iii) PROHIBITION ON FEDERAL EMPLOYMENT.—A member of the Committee shall not be an employee of the Federal Government.

''(iv) ETHICS DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of

the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(v) DATE OF INITIAL APPOINTMENTS.—The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

''(C) TERM; VACANCIES.—

''(i) TERM.—The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(ii) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a suc-

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

''(D) DUTIES.—The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

''(E) COMPENSATION OF MEMBERS.—

''(i) IN GENERAL.—Except as provided in clause (ii), a member of the Committee shall serve without compensation.

''(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

''(F) OPERATIONAL AND TECHNICAL SUPPORT.—

''(i) IN GENERAL.—The Assistant Secretary for Planning and Evaluation

shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

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

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

''(2) CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.—

"(i) RULEMAKING.—Not later than November 1, 2015, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

"(ii) MEDPAC SUBMISSION OF COMMENTS.—During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

"(iii) UPDATING.—The Secretary may update the criteria established under this subparagraph through rulemaking.

"(B) STAKEHOLDER SUBMISSION OF PHYSICIAN FOCUSED PAYMENT MODELS.—On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such in-

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

"(C) TAC REVIEW OF MODELS SUBMITTED.—The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

"(D) SECRETARY REVIEW AND RESPONSE.—The Secretary shall review the comments and recommendations submitted by the Committee under subparagraph (C) and post a detailed response to such comments and recommendations on the Internet Website of the Centers for Medicare & Medicaid Services.

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to impact the development or testing of models under this title or titles XI, XIX, or XXI.".

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

1395l) is amended by adding at the end the following new subsection:

"(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

"(1) PAYMENT INCENTIVE.—

"(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2018 and ending with 2023 and for which the professional is a qualifying APM participant, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the payment amount for the covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases where payment for covered professional services furnished by a qualifying APM participant in

an alternative payment model is made to an entity participating in the alternative payment model rather than directly to the qualifying APM participant.

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

"(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

"(D) COORDINATION.—The amount of the additional payment for an item or service under this subsection or subsection (m) shall be determined without regard to any additional payment for the item or service under subsection (m) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (x) shall be determined without regard to any additional payment for the item or service under subsection (x) and this subsection, re-

spectively. The amount of the additional payment for an item or service under this subsection or subsection (y) shall be determined without regard to any additional payment for the item or service under subsection (y) and this subsection, respectively.

''(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term 'qualifying APM participant' means the following:

''(A) 2018 AND 2019.—With respect to 2018 and 2019, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

''(B) 2020 AND 2021.—With respect to 2020 and 2021, an eligible professional described in either of the following clauses:

''(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for

whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

''(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

''(aa) payments described in clause (i); and

''(bb) all other payments, regardless of payer (other than payments made by the Secretary

of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law, and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished

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

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

''(aa) quality measures comparable to measures under the

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

"(bb) certified EHR technology is used; and

"(cc) the eligible professional (AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or (BB) is a medical home (with respect to beneficiaries under title XIX) that meets criteria comparable to medical homes expanded under section 1115A(c).

"(C) BEGINNING IN 2022.—With respect to 2022 and each subsequent year, an eligible professional described in either of the following clauses:

"(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are

available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

''(ii) COMBINATION ALL-PAYER AND MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional—

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

''(aa) payments described in clause (i); and

''(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of

law, and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

''(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

''(bb) certified EHR technology is used; and

"(cc) the eligible professional (AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or (BB) is a medical home (with respect to beneficiaries under title XIX) that meets criteria comparable to medical homes expanded under section 1115A(c).

"(3) ADDITIONAL DEFINITIONS.—In this subsection:

"(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given that term in section 1848(k)(3)(A).

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

"(C) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means any of the following:

"(i) A model under section 1115A (other than a health care innovation award).

"(ii) The shared savings program under section 1899.

"(iii) A demonstration under section 1866C.

"(iv) A demonstration required by Federal law.

"(D) ELIGIBLE ALTERNATIVE PAYMENT MODEL (APM).—

"(i) IN GENERAL.—The term 'eligible alternative payment model' means, with respect to a year, an alternative payment model—

"(I) that requires use of certified EHR technology (as defined in subsection (o)(4));

"(II) that provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

"(III) that satisfies the requirement described in clause (ii).

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

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

''(I) is one in which one or more entities bear financial risk for monetary losses under such model that are in excess of a nominal amount; or

''(II) is a medical home expanded under section 1115A(c).

''(4) LIMITATION.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the following:

''(A) The determination that an eligible professional is a qualifying APM participant under paragraph (2) and the determination that an alternative payment model is an eligible alternative payment model under paragraph (3)(D).

''(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.''.

(3) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended—

(A) in subsection (x)(3), by adding at the end the following new sentence: ''The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.''; and

(B) in subsection (y)(3), by adding at the end the following new sentence: ''The amount of the additional payment for a service under this subsection and subsection (z) shall be determined without regard to any additional payment for the service under subsection (z) and this subsection, respectively.''.

(4) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.—Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

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

''(xxi) Focusing primarily on physicians' services (as defined in section

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

''(xxii) Focusing on practices of 15 or fewer professionals.

''(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

''(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services.''; and

(B) in subparagraph (C)(viii), by striking ''other public sector or private sector payers'' and inserting ''other public sector payers, private sector payers, or Statewide payment models''.

(5) CONSTRUCTION REGARDING TELEHEALTH SERVICES.—Nothing in the provisions of, or amendments made by, this Act shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by

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

(6) INTEGRATING MEDICARE ADVANTAGE ALTERNATIVE PAYMENT MODELS.—Not later than July 1, 2015, the Secretary of Health and Human Services shall submit to Congress a study that examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system. The study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

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

(A) STUDY.—The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

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

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

(ii) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(iii) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subparagraph (A). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

(f) IMPROVING PAYMENT ACCURACY.—

(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE.—

(A) STUDY USING EXISTING MEDICARE DATA.—

(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

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

(B) STUDY USING OTHER DATA.—

(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors, such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and patient activation, on quality and resource use outcome measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

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

report on the study conducted under clause (i).

(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality and resource use outcome measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

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

on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

(ii) account for such factors in determining payment adjustments based on quality and resource use outcome measures under the eligible professional Merit-based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)) and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(E) FUNDING.—There are hereby appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act to the Secretary to carry out this paragraph $6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) HIERARCHAL CONDITION CATEGORY (HCC) IMPROVEMENT.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1), the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate, estimate how

an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into provisions of title XVIII of the Social Security Act that are similar to the eligible professional Merit-based Incentive Payment System under section 1848(q) of such Act.

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

(i) IN GENERAL.—Taking into account the studies conducted and recommendations made in reports under paragraph (1) and other information as appropriate, the Secretary shall, as the Secretary determines appropriate, account for identified factors with an effect on quality and resource use outcome measures when determining payment adjustment mechanisms under provisions of title XVIII of the Social Security Act that are similar to the eligible professional Merit-based Incen-

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

(ii) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

(iii) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in clause (i) so as to monitor changes in possible relationships.

(C) FUNDING.—There are hereby appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act to the Secretary to carry out this paragraph and the application of this paragraph to the Merit-based Incentive Payment System under section 1848(q) of such Act $10,000,000, to remain available until expended.

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

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

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

''(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

''(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the Merit-based Incentive Payment System under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

"(2) DEVELOPMENT OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—

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

"(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 120 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to subsection (n)(9)(A) and related descriptive information.

"(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 60 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and

specific clinical criteria and patient characteristics to classify patients into—

"(i) care episode groups; and

"(ii) patient condition groups.

"(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

"(i) IN GENERAL.—Taking into account the information described in subparagraph (B) and the information received under subparagraph (C), the Secretary shall—

"(I) establish care episode groups and patient condition groups, which account for a target of an estimated ⅔ of expenditures under parts A and B; and

"(II) assign codes to such groups.

"(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under clause (i), the Secretary shall take into account—

"(I) the patient's clinical problems at the time items and services are furnished during an episode of

care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and

''(II) other factors determined appropriate by the Secretary.

''(iii) PATIENT CONDITION GROUPS.—In establishing the patient condition groups under clause (i), the Secretary shall take into account—

''(I) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

''(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

"(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 180 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

"(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

"(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 180 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

"(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2017), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

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

''(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

''(i) considers themself to have the primary responsibility for the general and

ongoing care for the patient over extended periods of time;

''(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

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

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

''(v) furnishes items and services only as ordered by another physician or practitioner.

''(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 270 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient re-

lationship categories and codes developed under subparagraph (B).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

''(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 180 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for

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

''(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2017), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2017, shall, as determined appropriate by the Secretary, include—

''(A) applicable codes established under paragraphs (2) and (3); and

''(B) the national provider identifier of the ordering physician or applicable practitioner (if

different from the billing physician or applicable practitioner).

''(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

''(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall—

''(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners;

''(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

''(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

''(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with

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

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

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

"(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

"(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

"(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

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

appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

''(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

''(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

''(7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) care episode and patient condition groups and codes established under paragraph (2);

''(B) patient relationship categories and codes established under paragraph (3); and

''(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

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

''(9) DEFINITIONS.—In this section:

''(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

''(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

''(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

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

''(10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.''.

**SEC. 102. PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.**

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (g) of section 101, is further amended by inserting at the end the following new subsection:

"(s) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

"(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

"(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2015, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

"(i) address how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;

"(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

"(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

''(B) QUALITY DOMAINS.—For purposes of this subsection, the term 'quality domains' means at least the following domains:

''(i) Clinical care.

''(ii) Safety.

''(iii) Care coordination.

''(iv) Patient and caregiver experience.

''(v) Population health and prevention.

''(C) CONSIDERATION.—In developing the draft plan under this paragraph, the Secretary shall consider—

''(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;

''(ii) whether measures are applicable across health care settings;

''(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

''(iv) the quality domains applied under this subsection.

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

''(i) Outcome measures, including patient reported outcome and functional status measures.

''(ii) Patient experience measures.

''(iii) Care coordination measures.

''(iv) Measures of appropriate use of services, including measures of over use.

''(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2015, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

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

sions. Such plan shall be updated as appropriate.

''(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

''(B) PRIORITIZATION.—

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

''(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

''(I) whether such measures would be electronically specified; and

''(II) clinical practice guidelines to the extent that such guidelines exist.

''(3) ANNUAL REPORT BY THE SECRETARY.—

''(A) IN GENERAL.—Not later than May 1, 2016, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

''(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

''(i) A description of the Secretary's efforts to implement this paragraph.

''(ii) With respect to the measures developed during the previous year—

''(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

''(II) the name of each measure developed;

"(III) the name of the developer and steward of each measure;

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

"(V) whether the measure would be electronically specified.

"(iii) With respect to measures in development at the time of the report—

"(I) the information described in clause (ii), if available; and

"(II) a timeline for completion of the development of such measures.

"(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

"(v) Other information the Secretary determines to be appropriate.

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

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

"(B) prioritizing quality measure development to address such gaps; and

"(C) other areas related to quality measure development determined appropriate by the Secretary.

"(5) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term 'applicable provisions' means the following provisions:

"(A) Subsection (q)(2)(B)(i).

"(B) Section 1833(z)(2)(C).

"(6) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2021.".

**SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.**

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

''(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

''(A) IN GENERAL.—In order to encourage the management of care by an applicable provider (as defined in subparagraph (B)) for individuals with chronic care needs the Secretary shall—

''(i) establish one or more HCPCS codes for chronic care management services for such individuals; and

''(ii) subject to subparagraph (D), make payment (as the Secretary determines to be appropriate) under this section for such management services furnished on or after January 1, 2015, by an applicable provider.

''(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section

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

"(i) is recognized as such a medical home or comparable specialty practice by an organization that is recognized by the Secretary for purposes of such recognition as such a medical home or practice; or

"(ii) meets such other comparable qualifications as the Secretary determines to be appropriate.

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

"(D) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

"(i) make payment to only one applicable provider for such services furnished to an individual during a period;

''(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services (such as in the case of hospice care or home health services); and

''(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.''.

(b) EDUCATION AND OUTREACH.—

(1) CAMPAIGN.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act, as added by subsection (a),

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

(B) REQUIREMENTS.—Such campaign shall—

(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

(2) REPORT.—

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

(i) identify barriers to receiving chronic care management services; and

(ii) make recommendations for increasing the appropriate use of chronic care management services.

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

(a) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

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

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

''(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

''(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate)

use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

''(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

''(I) Time involved in furnishing services.

''(II) Amounts and types of practice expense inputs involved with furnishing services.

''(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

''(IV) Overhead and accounting information for practices of physicians and other suppliers.

''(V) Any other element that would improve the valuation of services under this section.

''(iv) INFORMATION COLLECTION MECHANISMS.—Information may be col-

lected or obtained pursuant to this subparagraph from any or all of the following:

"(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

"(II) Surgical logs, billing systems, or other practice or facility records.

"(III) Electronic health records.

"(IV) Any other mechanism determined appropriate by the Secretary.

"(v) TRANSPARENCY OF USE OF INFORMATION.—

"(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

"(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

"(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

"(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be

provided in a form and manner specified by the Secretary.

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

''(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term 'eligible professional' has the meaning given such term in subsection (k)(3)(B).

''(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.''.

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

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

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

''(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).''.

(b) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).''.

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

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

"(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

"(I) Codes that have experienced the fastest growth.

"(II) Codes that have experienced substantial changes in practice expenses.

"(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

"(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

"(V) Codes with low relative values, particularly those that are often

billed multiple times for a single treatment.

''(VI) Codes that have not been subject to review since implementation of the fee schedule.

''(VII) Codes that account for the majority of spending under the physician fee schedule.

''(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

''(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

''(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

''(XI) Codes for which there may be anomalies in relative values within a family of codes.

''(XII) Codes for services where there may be efficiencies when a serv-

ice is furnished at the same time as other services.

"(XIII) Codes with high intra-service work per unit of time.

"(XIV) Codes with high practice expense relative value units.

"(XV) Codes with high cost supplies.

"(XVI) Codes as determined appropriate by the Secretary.".

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

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

"(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2015 through 2018, the following shall apply:

"(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with re-

spect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

''(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

''(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

''(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

''(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2015.

''(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

''(I) the target for the year; and

''(II) the estimated net reduction in expenditures determined under clause (i) for the year.

''(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.''.

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

"(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2015, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).".

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

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

"(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2015, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, prac-

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

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

(A) in subparagraph (B)(ii)(I), by striking ''subclause (II)'' and inserting ''subclause (II) and paragraph (7)''; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking ''provisions of subparagraph (B)(ii)(II)'' and inserting ''provisions of subparagraph (B)(ii)(II) and paragraph (7)''; and

(ii) by striking ''under subparagraph (B)(ii)(II)'' and inserting ''under subparagraph (B)(ii)(I)''.

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

(1) in each of clauses (i) and (iii), by striking ''the service'' and inserting ''the service or group of services'' each place it appears; and

(2) in the first sentence of clause (ii), by inserting ''or group of services'' before the period.

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

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

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

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

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

''(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

''(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

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

''(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

''(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to

be applied under this subsection for such year shall be equal to the sum of the following:

"(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

"(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

"(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

"(I) for 2017, is 5/6; and

"(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus 1/6.

"(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

"(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

"(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

"(i) The rest-of-State payment locality.

"(ii) Payment locality 3.

''(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.''.

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking ''The term'' and inserting ''Except as provided in subsection (e)(6)(D), the term''.

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

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

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

''(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

''(1) PROGRAM ESTABLISHED.—

''(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

''(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term 'appropriate use criteria' means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

"(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term 'applicable imaging service' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

"(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

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

"(iii) one or more of such mechanisms is available free of charge.

"(D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

"(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term 'ordering professional' means a physician (as defined in section 1861(r)) or a practitioner described in

section 1842(b)(18)(C) who orders an applicable imaging service for an individual.

''(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term 'furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

''(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities.

''(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

''(i) have stakeholder consensus;

"(ii) are scientifically valid and evidence based; and

"(iii) are based on studies that are published and reviewable by stakeholders.

"(C) REVISIONS.—The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rulemaking.

"(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criteria applies with respect to an applicable imaging service, the Secretary shall permit one or more applicable appropriate use criteria under this paragraph for the service.

"(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(i) IN GENERAL.—The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

''(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

''(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

''(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

''(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms

available from medical specialty organizations.

''(III) Use of a clinical decision support mechanism established by the Secretary.

''(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

''(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

''(ii) REQUIREMENTS.—The requirements described in this clause are the following:

''(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

''(II) In the case where there are more than one applicable appropriate use criteria specified under such paragraph for an applicable imaging serv-

ice, the mechanism indicates the criteria that it uses for the service.

''(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

''(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

''(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

''(VI) The mechanism meets privacy and security standards under applicable provisions of law.

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

quirement to provide aggregate feedback to the ordering professional.

''(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

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

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

''(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

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

"(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

"(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

"(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

"(ii) Information regarding—

"(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

''(II) whether the service ordered would not adhere to such criteria; or

''(III) whether such criteria was not applicable to the service ordered.

''(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

''(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

''(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

''(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

''(iii) ALTERNATIVE PAYMENT MODELS.—An applicable imaging service ordered by an ordering professional with respect to an individual attributed to an alternative payment model (as defined in section 1833(z)(3)(C)).

"(iv) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

"(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term 'applicable payment system' means the following:

"(i) The physician fee schedule established under section 1848(b).

"(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

"(iii) The ambulatory surgical center payment systems under section 1833(i).

"(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

"(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with

2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

''(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

''(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

''(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

''(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

''(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

''(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with

physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

"(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

"(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

"(B) APPROPRIATE USE CRITERIA IN PRIOR AUTHORIZATION.—In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

"(C) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Man-

agement Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.''.

(b) CONFORMING AMENDMENT.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

''(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(p).''.

(c) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under part B of title XVIII of the Social Security

Act (42 U.S.C. 1395j et seq.), such as radiation therapy and clinical diagnostic laboratory services.

**SEC. 106. EMPOWERING BENEFICIARY CHOICES THROUGH ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.**

(a) IN GENERAL.—The Secretary shall make publicly available on Physician Compare the information described in subsection (b) with respect to eligible professionals.

(b) INFORMATION DESCRIBED.—The following information, with respect to an eligible professional, is described in this subsection:

(1) Information on the number of services furnished by the eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

(2) Information on submitted charges and payments for services under such part.

(3) A unique identifier for the eligible professional that is available to the public, such as a national provider identifier.

(c) SEARCHABILITY.—The information made available under this section shall be searchable by at least the following:

(1) The specialty or type of the eligible professional.

(2) Characteristics of the services furnished, such as volume or groupings of services.

(3) The location of the eligible professional.

(d) DISCLOSURE.—The information made available under this section shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(e) IMPLEMENTATION.—

(1) INITIAL IMPLEMENTATION.—Physician Compare shall include the information described in subsection (b)—

(A) with respect to physicians, by not later than July 1, 2015; and

(B) with respect to other eligible professionals, by not later than July 1, 2016.

(2) ANNUAL UPDATING.—The information made available under this section shall be updated on Physician Compare not less frequently than on an annual basis.

(f) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity

for an eligible professional to review, and submit corrections for, the information to be made public with respect to the eligible professional under this section prior to such information being made public.

(g) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SECRETARY.—The terms ''eligible professional'', ''physician'', and ''Secretary'' have the meaning given such terms in section 10331(i) of Public Law 111–148.

(2) PHYSICIAN COMPARE.—The term ''Physician Compare'' means the Physician Compare Internet website of the Centers for Medicare & Medicaid Services (or a successor website).

**SEC. 107. EXPANDING AVAILABILITY OF MEDICARE DATA.**

(a) EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES.—

(1) ADDITIONAL ANALYSES.—

(A) IN GENERAL.—Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2015, a quali-

fied entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) LIMITATIONS WITH RESPECT TO ANALYSES.—

(i) EMPLOYERS.—Any analyses provided or sold under subparagraph (A) to an employer described in paragraph (9)(A)(iii) may only be used by such employer for purposes of providing health insurance to employees and retirees of the employer.

(ii) HEALTH INSURANCE ISSUERS.—A qualified entity may not provide or sell an analysis to a health insurance issuer de-

scribed in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) ACCESS TO CERTAIN DATA.—

(A) ACCESS.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2015, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, in-

cluding for the purposes described in subparagraph (B).

(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) MEDICARE CLAIMS DATA MUST BE PROVIDED AT NO COST.—A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) PROTECTION OF INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individ-

ually identifies a patient of such provider or supplier, including with respect to items and services furnished to the patient by other providers of services or suppliers.

(C) PROHIBITION ON USING ANALYSES OR DATA FOR MARKETING PURPOSES.—An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

(4) DATA USE AGREEMENT.—A qualified entity and an authorized user described in clauses (i), (ii), and (v) of paragraph (9)(A) shall enter into an agreement regarding the use of any data that the qualified entity is providing or selling to the authorized user under paragraph (2). Such agreement shall describe the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using such data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under the rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, the agreement shall identify the relevant regulations, as determined by the Secretary, that the

user shall comply with as if it were acting in the capacity of such a covered entity.

(5) NO REDISCLOSURE OF ANALYSES OR DATA.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an authorized user that is provided or sold an analysis or data under paragraph (1) or (2) shall not redisclose or make public such analysis or data or any analysis using such data.

(B) PERMITTED REDISCLOSURE.—A provider of services or supplier that is provided or sold an analysis or data under paragraph (1) or (2) may, as determined by the Secretary, redisclose such analysis or data for the purposes of performance improvement and care coordination activities but shall not make public such analysis or data or any analysis using such data.

(6) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity

shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

(A) IN GENERAL.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

(B) ASSESSMENT.—The assessment under subparagraph (A) shall be an amount up to $100 for each individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title—

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(8) ANNUAL REPORTS.—Any qualified entity that provides or sells an analysis or data under paragraph (1) or (2) shall annually submit to the Secretary a report that includes—

(A) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses;

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and

(D) other information determined appropriate by the Secretary.

(9) DEFINITIONS.—In this subsection and subsection (b):

(A) AUTHORIZED USER.—The term ''authorized user'' means the following:

(i) A provider of services.

(ii) A supplier.

(iii) An employer (as defined in section 3(5) of the Employee Retirement Insurance Security Act of 1974).

(iv) A health insurance issuer (as defined in section 2791 of the Public Health Service Act).

(v) A medical society or hospital association.

(vi) Any entity not described in clauses (i) through (v) that is approved by the Secretary (other than an employer or health insurance issuer not described in clauses (iii) and (iv), respectively, as determined by the Secretary).

(B) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given

such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(C) QUALIFIED ENTITY.—The term ''qualified entity'' has the meaning given such term in section 1874(e)(2) of the Social Security Act (42 U.S.C. 1395kk(e)).

(D) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(E) SUPPLIER.—The term ''supplier'' has the meaning given such term in section 1861(d) of the Social Security Act (42 U.S.C. 1395x(d)).

(b) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—

(1) ACCESS.—

(A) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2015, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and

manner determined to be appropriate) to such qualified clinical data registry for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety, provided that any public reporting of such analyses or research that identifies a provider of services or supplier shall only be conducted with the opportunity of such provider or supplier to appeal and correct errors in the manner described in subsection (a)(6).

(B) DATA DESCRIBED.—The data described in this subparagraph is—

(i) claims data under the Medicare program under title XVIII of the Social Security Act; and

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act and the State Children's Health Insurance Program under title XXI of such Act.

(2) FEE.—Data described in paragraph (1)(B) shall be provided to a qualified clinical data registry under paragraph (1) at a fee equal to the cost of

providing such data. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

(c) EXPANSION OF DATA AVAILABLE TO QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended—

(1) in the subsection heading, by striking ''MEDICARE''; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: ''Beginning July 1, 2015, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.''; and

(B) in the last sentence, by inserting ''or under titles XIX or XXI'' before the period at the end.

(d) REVISION OF PLACEMENT OF FEES.—Section 1874(e)(4)(A) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(A)) is amended, in the second sentence—

(1) by inserting ", for periods prior to July 1, 2015," after "deposited"; and

(2) by inserting the following before the period at the end: ", and, beginning July 1, 2015, into the Centers for Medicare & Medicaid Services Program Management Account".

**SEC. 108. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.**

(a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-OUT TO PRIVATE CONTRACT.—

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

(A) IN GENERAL.—Section 1802(b)(3) of the Social Security Act (42 U.S.C. 1395a(b)(3)) is amended—

(i) in subparagraph (B)(ii), by striking "during the 2-year period beginning on the date the affidavit is signed" and inserting "during the applicable 2-year period (as defined in subparagraph (D))";

(ii) in subparagraph (C), by striking "during the 2-year period described in sub-

paragraph (B)(ii)'' and inserting ''during the applicable 2-year period''; and

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

''(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.''.

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply to affidavits entered into on or after the date that is 60 days after the date of the enactment of this Act.

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a(b)) is amended—

(A) in paragraph (5), by adding at the end the following new subparagraph:

''(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).'';

(B) by redesignating paragraph (5) as paragraph (6); and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

''(A) IN GENERAL.—Beginning not later than February 1, 2015, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

"(B) INFORMATION TO BE INCLUDED.—The information to be made available under subparagraph (A) shall include at least the following with respect to opt-out physicians and practitioners:

"(i) Their number.

"(ii) Their physician or professional specialty or other designation.

"(iii) Their geographic distribution.

"(iv) The timing of their becoming opt-out physicians and practitioners, relative to when they first entered practice and with respect to applicable 2-year periods.

"(v) The proportion of such physicians and practitioners who billed for emergency or urgent care services.".

(b) GAINSHARING STUDY AND REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with legislative recommendations to amend existing fraud and abuse laws, through exceptions, safe harbors, or other narrowly targeted provisions, to permit

gainsharing or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships;

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program under title XVIII of the Social Security Act.

(c) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORD SYSTEMS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health infor-

mation through interoperable certified EHR technology nationwide by December 31, 2017.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term ''widespread interoperability'' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

(ii) INTEROPERABILITY.—The term ''interoperability'' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2015, and in consultation with stakeholders, the Secretary shall establish metrics to be used to determine if and to the

extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2017, then the Secretary shall submit to Congress a report, by not later than December 31, 2018, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before the period at the end the following: ‘‘, and the

professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken any action to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(B) FOR MEANINGFUL EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: '', and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken any action to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is one year after the date of the enactment of this Act.

(3) STUDY AND REPORT ON THE FEASIBILITY OF ESTABLISHING A WEBSITE TO COMPARE CERTIFIED EHR TECHNOLOGY PRODUCTS.—

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing mechanisms that includes aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products. Such information may be made available through contracts with physician, hospital, or other organizations that maintain such comparative information.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the website. The report shall include information on the benefits of, and resources needed to develop and maintain, such a website.

(4) DEFINITIONS.—In this subsection:

(A) The term ''certified EHR technology'' has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term ''meaningful EHR user'' has the meaning given such term under the Medicare EHR incentive programs.

(C) The term ''Medicare and Medicaid EHR incentive programs'' means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w–4(o), 1395w–23, 1395ww(n)); and

(ii) in the case of the Medicaid program under title XIX of such Act, the incentive program under subsections (a)(3)(F) and (t) of section 1903 of such Act (42 U.S.C. 1396b).

(D) The term ''Secretary'' means the Secretary of Health and Human Services.

(d) GAO STUDIES AND REPORTS ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS AND ON REMOTE PATIENT MONITORING SERVICES.—

(1) STUDY ON TELEHEALTH SERVICES.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and Federal efforts

can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(B) Issues that can facilitate or inhibit the use of telehealth under the Medicare program under such title, including oversight and professional licensure, changing technology, privacy and security, infrastructure requirements, and varying needs across urban and rural areas.

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services conducts oversight of payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) STUDY ON REMOTE PATIENT MONITORING SERVICES.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study—

(i) of the dissemination of remote patient monitoring technology in the private health insurance market;

(ii) of the financial incentives in the private health insurance market relating to adoption of such technology;

(iii) of the barriers to adoption of such services under the Medicare program under title XVIII of the Social Security Act;

(iv) that evaluates the patients, conditions, and clinical circumstances that could most benefit from remote patient monitoring services; and

(v) that evaluates the challenges related to establishing appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) in order to accurately reflect the resources involved in furnishing such services.

(B) DEFINITIONS.—For purposes of this paragraph:

(i) REMOTE PATIENT MONITORING SERVICES.—The term ''remote patient monitoring services'' means services furnished through remote patient monitoring technology.

(ii) REMOTE PATIENT MONITORING TECHNOLOGY.—The term ''remote patient monitoring technology'' means a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or information on activities of daily living and may include responses to assessment questions collected on the devices wirelessly or through a telecommunications connection to a server that complies with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as part of an established plan of care for that patient that includes the review and interpretation of that data by a health care professional.

(3) REPORTS.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress—

(A) a report containing the results of the study conducted under paragraph (1); and

(B) a report containing the results of the study conducted under paragraph (2).

A report required under this paragraph shall be submitted together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate. The Comptroller General may submit one report containing the results described in subparagraphs (A) and (B) and the recommendations described in the previous sentence.

(e) RULE OF CONSTRUCTION REGARDING HEALTHCARE PROVIDER STANDARDS OF CARE.—

(1) MAINTENANCE OF STATE STANDARDS.—The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed—

(A) to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim; or

(B) to preempt any standard of care or duty of care, owed by a health care provider to a patient, duly established under State or common law.

(2) DEFINITIONS.—For purposes of this subsection:

(A) FEDERAL HEALTH CARE PROVISION.—The term ''Federal health care provision'' means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act.

(B) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity—

(i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) MEDICAL MALPRACTICE OR MEDICAL PRODUCT LIABILITY ACTION OR CLAIM.—The

term ''medical malpractice or medical product liability action or claim'' means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) PRESERVATION OF STATE LAW.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

# TITLE II—EXTENSIONS

## Subtitle A—Medicare Extensions

**SEC. 201. WORK GEOGRAPHIC ADJUSTMENT.**

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''and before April 1, 2014,''.

**SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES.**

(a) REPEAL OF THERAPY CAP AND 1-YEAR EXTENSION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (4)—

(A) by striking ''This subsection'' and inserting ''Except as provided in paragraph (5)(C)(iii), this subsection''; and

(B) by inserting the following before the period at the end: ''or with respect to services furnished on or after the date of enactment of the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014''; and

(2) in paragraph (5)(C), by adding at the end the following new clause:

''(iii) Beginning on the date of enactment of the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014 and ending on the day before the date

that is 12 months after such date of enactment, the manual medical review process described in clause (i) shall apply with respect to expenses incurred in a year for services described in paragraphs (1) and (3) that exceed the threshold described in clause (ii) for the year.''.

(b) MEDICAL REVIEW OF OUTPATIENT THERAPY SERVICES.—

(1) MEDICAL REVIEW OF OUTPATIENT THERAPY SERVICES.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 101(e)(2), is amended by adding at the end the following new subsection:

''(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY SERVICES.—

''(1) IN GENERAL.—

''(A) PROCESS FOR MEDICAL REVIEW.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of outpatient therapy services (as defined in paragraph (10)) and, subject to paragraph (12), apply such process to such services furnished on or after the date that is 12 months after the date of enactment of the Medicare SGR Repeal and Beneficiary Access Improve-

ment Act of 2014, focusing on services identified under subparagraph (B).

''(B) IDENTIFICATION OF SERVICES FOR REVIEW.—Under the process, the Secretary shall identify services for medical review, using such factors as the Secretary determines appropriate, which may include the following:

''(i) Services furnished by a therapy provider (as defined in paragraph (10)) whose pattern of billing is aberrant compared to peers.

''(ii) Services furnished by a therapy provider who, in a prior period, has a high claims denial percentage or is less compliant with other applicable requirements under this title.

''(iii) Services furnished by a therapy provider that is newly enrolled under this title.

''(iv) Services furnished by a therapy provider who has questionable billing practices, such as billing medically unlikely units of services in a day.

''(v) Services furnished to treat a type of medical condition.

''(vi) Services identified by use of the standardized data elements required to be reported under section 1834(p).

''(vii) Services furnished by a single therapy provider or a group that includes a therapy provider identified by factors described in this subparagraph.

''(viii) Other services as determined appropriate by the Secretary.

''(2) MEDICAL REVIEW.—

''(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

''(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, the Secretary shall use prior authorization medical review for outpatient therapy services furnished to an individual above one or more thresholds established by the Secretary, such as a dollar threshold or a threshold based on other factors.

''(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION FOR A THERAPY PROVIDER.—The Secretary shall end the application of prior authorization medical review to outpatient therapy services fur-

nished by a therapy provider if the Secretary determines that the provider has a low denial rate under such prior authorization. The Secretary may subsequently reapply prior authorization medical review to such therapy provider if the Secretary determines it to be appropriate.

''(iii) PRIOR AUTHORIZATION OF MULTIPLE SERVICES.—The Secretary shall, where practicable, provide for prior authorization medical review for multiple services at a single time, such as services in a therapy plan of care described in section 1861(p)(2).

''(B) OTHER TYPES OF MEDICAL REVIEW.—The Secretary may use pre-payment review or post-payment review for services identified under paragraph (1)(B) that are not subject to prior authorization medical review under subparagraph (A).

''(C) LIMITATION FOR LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

''(3) REVIEW CONTRACTORS.—The Secretary shall conduct prior authorization medical review of outpatient therapy services under this subsection using medicare administrative contractors (as described in section 1874A) or other review contractors (other than contractors under section 1893(h) or contractors paid on a contingent basis).

''(4) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to an outpatient therapy service for which prior authorization medical review under this subsection applies, the following shall apply:

''(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

''(B) DENIAL OF PAYMENT.—Subject to paragraph (6), no payment shall be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that the service would meet the applicable requirements of such section.

''(5) SUBMISSION OF INFORMATION.—A therapy provider may submit the information necessary

for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable, but not later than 24 months after the date of enactment of this subsection.

''(6) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (4)(A) within 10 business days of the date of the Secretary's receipt of medical documentation needed to make such determination, paragraph (4)(B) shall not apply.

''(7) CONSTRUCTION.—With respect to an outpatient therapy service that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.

''(8) BENEFICIARY PROTECTIONS.—With respect to services furnished on or after January 1, 2015, where payment may not be made as a result of application of medical review under this subsection, section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

''(9) IMPLEMENTATION.—

''(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.

''(C) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the identification of services for medical review or the process for medical review under this subsection.

''(10) DEFINITIONS.—For purposes of this subsection:

''(A) OUTPATIENT THERAPY SERVICES.—The term 'outpatient therapy services' means the following services for which payment is made under section 1848, 1834(g), or 1834(k):

''(i) Physical therapy services of the type described in section 1861(p).

''(ii) Speech-language pathology services of the type described in such section though the application of section 1861(ll)(2).

"(iii) Occupational therapy services of the type described in section 1861(p) through the operation of section 1861(g).

"(B) THERAPY PROVIDER.—The term 'therapy provider' means a provider of services (as defined in section 1861(u)) or a supplier (as defined in section 1861(d)) who submits a claim for outpatient therapy services.

"(11) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year (beginning with fiscal year 2014). Amounts transferred under this paragraph shall remain available until expended.

"(12) SCALING BACK.—

"(A) PERIODIC DETERMINATIONS.—Beginning with 2017, and every two years thereafter, the Secretary shall—

"(i) make a determination of the improper payment rate for outpatient therapy services for a 12-month period; and

''(ii) make such determination publicly available.

''(B) SCALING BACK.—If the improper payment rate for outpatient therapy services determined for a 12-month period under subparagraph (A) is 50 percent or less of the Medicare fee-for-service improper payment rate for such period, the Secretary shall—

''(i) reduce the amount and extent of medical review conducted for a prospective year under the process established in this subsection; and

''(ii) return an appropriate portion of the funding provided for such year under paragraph (11).''.

(2) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of medical review of outpatient therapy services under section 1833(aa) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of—

(i) aggregate data on—

(I) the number of individuals, therapy providers, and claims subject to such review; and

(II) the number of reviews conducted under such section; and

(ii) the outcomes of such reviews.

(B) REPORT.—Not later than 3 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) COLLECTION OF STANDARDIZED DATA ELEMENTS FOR OUTPATIENT THERAPY SERVICES.—

(1) COLLECTION OF STANDARDIZED DATA ELEMENTS FOR OUTPATIENT THERAPY SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(p) COLLECTION OF STANDARDIZED DATA ELEMENTS FOR OUTPATIENT THERAPY SERVICES.—

''(1) STANDARDIZED DATA ELEMENTS.—

"(A) IN GENERAL.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of standardized data elements for individuals receiving outpatient therapy services.

"(B) DOMAINS.—Such standardized data elements shall include information with respect to the following domains, as determined appropriate by the Secretary:

"(i) Demographic information.

"(ii) Diagnosis.

"(iii) Severity.

"(iv) Affected body structures and functions.

"(v) Limitations with activities of daily living and participation.

"(vi) Functional status.

"(vii) Other domains determined to be appropriate by the Secretary.

"(C) SOLICITATION OF INPUT.—The Secretary shall accept comments from stakeholders through the date that is 60 days after the date the Secretary posts the draft list of standard-

ized data elements pursuant to subparagraph (A). In seeking such comments, the Secretary shall use one or more mechanisms to solicit input from stakeholders that may include use of open door forums, town hall meetings, requests for information, or other mechanisms determined appropriate by the Secretary.

''(D) OPERATIONAL LIST OF STANDARDIZED DATA ELEMENTS.—Not later than 120 days after the end of the comment period described in subparagraph (C), the Secretary, taking into account such comments, shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of standardized data elements.

''(E) SUBSEQUENT REVISIONS.—Subsequent revisions to the operational list of standardized data elements shall be made through rulemaking. Such revisions may be based on experience and input from stakeholders.

''(2) SYSTEM TO REPORT STANDARDIZED DATA ELEMENTS.—

''(A) IN GENERAL.—Not later than 18 months after the date the Secretary posts the operational list of standardized data elements

pursuant to paragraph (1)(D), the Secretary shall develop and implement an electronic system (which may be a web portal) for therapy providers to report the standardized data elements for individuals with respect to outpatient therapy services.

''(B) CONSULTATION.—The Secretary shall seek comments from stakeholders regarding the best way to report the standardized data elements.

''(3) REPORTING.—

''(A) FREQUENCY OF REPORTING.—The Secretary shall specify the frequency of reporting standardized data elements. The Secretary shall seek comments from stakeholders regarding the frequency of the reporting of such data elements.

''(B) REPORTING REQUIREMENT.—Beginning on the date the system to report standardized data elements under this subsection is operational, no payment shall be made under this part for outpatient therapy services furnished to an individual unless a therapy provider reports the standardized data elements for such individual.

''(4) REPORT ON NEW PAYMENT SYSTEM FOR OUTPATIENT THERAPY SERVICES.—

''(A) IN GENERAL.—Not later than 24 months after the date described in paragraph (3)(B), the Secretary shall submit to Congress a report on the design of a new payment system for outpatient therapy services. The report shall include an analysis of the standardized data elements collected and other appropriate data and information.

''(B) FEATURES.—Such report shall consider—

''(i) appropriate adjustments to payment (such as case mix and outliers);

''(ii) payments on an episode of care basis; and

''(iii) reduced payment for multiple episodes.

''(C) CONSULTATION.—The Secretary shall consult with stakeholders regarding the design of such a new payment system.

''(5) IMPLEMENTATION.—

''(A) FUNDING.—For purposes of implementing this subsection, the Secretary shall provide for the transfer, from the Federal Sup-

plementary Medical Insurance Trust Fund under section 1841, of $7,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this subparagraph shall remain available until expended.

''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to specification of the standardized data elements and implementation of the system to report such standardized data elements under this subsection.

''(C) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the specification of standardized data elements required under this subsection or the system to report such standardized data elements.

''(D) DEFINITION OF OUTPATIENT THERAPY SERVICES AND THERAPY PROVIDER.—In this subsection, the terms 'outpatient therapy services' and 'therapy provider' have the meaning given those term in section 1833(aa).''.

(2) SUNSET OF CURRENT CLAIMS-BASED COLLECTION OF THERAPY DATA.—Section 3005(g)(1) of the Middle Class Tax Extension and Job Creation Act of 2012 (42 U.S.C. 1395l note) is amended, in the first sentence, by inserting ''and ending on the date the system to report standardized data elements under section 1834(p) of the Social Security Act (42 U.S.C. 1395m(p)) is implemented,'' after ''January 1, 2013,''.

(d) REPORTING OF CERTAIN INFORMATION.—Section 1842(t) of the Social Security Act (42 U.S.C. 1395u(t)) is amended by adding at the end the following new paragraph:

''(3) Each request for payment, or bill submitted, by a therapy provider (as defined in section 1833(aa)(10)) for an outpatient therapy service (as defined in such section) furnished by a therapy assistant on or after January 1, 2015, shall include (in a form and manner specified by the Secretary) an indication that the service was furnished by a therapy assistant.''.

**SEC. 203. MEDICARE AMBULANCE SERVICES.**

(a) EXTENSION OF CERTAIN AMBULANCE ADD-ON PAYMENTS.—

(1) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C.

1395m(l)(13)(A)) is amended by striking ''April 1, 2014'' and inserting ''January 1, 2019'' each place it appears.

(2) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended, in the first sentence, by striking ''April 1, 2014'' and inserting ''January 1, 2019''.

(b) REQUIRING AMBULANCE PROVIDERS TO SUBMIT COST AND OTHER INFORMATION.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended by adding at the end the following new paragraph:

''(16) SUBMISSION OF COST AND OTHER INFORMATION.—

''(A) DEVELOPMENT OF DATA COLLECTION SYSTEM.—The Secretary shall develop a data collection system (which may include use of a cost survey and standardized definitions) for providers and suppliers of ambulance services to collect cost, revenue, utilization, and other information determined appropriate by the Secretary. Such system shall be designed to submit information—

''(i) needed to evaluate the appropriateness of payment rates under this subsection;

''(ii) on the utilization of capital equipment and ambulance capacity; and

''(iii) on different types of ambulance services furnished in different geographic locations, including rural areas and low population density areas described in paragraph (12).

''(B) SPECIFICATION OF DATA COLLECTION SYSTEM.—

''(i) IN GENERAL.—Not later than July 1, 2015, the Secretary shall—

''(I) specify the data collection system under subparagraph (A) and the time period during which such data is required to be submitted; and

''(II) identify the providers and suppliers of ambulance services who would be required to submit the information under such data collection system.

''(ii) RESPONDENTS.—Subject to subparagraph (D)(ii), the Secretary shall de-

termine an appropriate sample of providers and suppliers of ambulance services to submit information under the data collection system for each period for which reporting of data is required.

''(C) PENALTY FOR FAILURE TO REPORT COST AND OTHER INFORMATION.—Beginning on July 1, 2016, a 5 percent reduction to payments under this part shall be made for a 1-year prospective period specified by the Secretary to a provider or supplier of ambulance services who—

''(i) is identified under subparagraph (B)(i)(II) as being required to submit the information under the data collection system; and

''(ii) does not submit such information during the period specified under subparagraph (B)(i)(I).

''(D) ONGOING DATA COLLECTION.—

''(i) REVISION OF DATA COLLECTION SYSTEM.—The Secretary may, as determined appropriate, periodically revise the data collection system.

"(ii) SUBSEQUENT DATA COLLECTION.—In order to continue to evaluate the appropriateness of payment rates under this subsection, the Secretary shall, for years after 2016 (but not less often than once every 3 years), require providers and suppliers of ambulance services to submit information for a period the Secretary determines appropriate. The penalty described in subparagraph (C) shall apply to such subsequent data collection periods.

"(E) CONSULTATION.—The Secretary shall consult with stakeholders in carrying out the development of the system and collection of information under this paragraph, including the activities described in subparagraphs (A) and (D). Such consultation shall include the use of requests for information and other mechanisms determined appropriate by the Secretary.

"(F) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information required under this subsection.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review

under section 1869, section 1878, or otherwise of the data collection system or identification of respondents under this paragraph.

''(H) FUNDING FOR IMPLEMENTATION.—For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $1,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2014. Amounts transferred under this subparagraph shall remain available until expended.''.

**SEC. 204. REVISION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.**

(a) PERMANENT EXTENSION OF PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ''and before April 1, 2014,''; and

(B) in clause (ii)(II), by striking ''and before April 1, 2014,''.

(2) CONFORMING AMENDMENTS.—

(A) TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(i) in the matter preceding clause (i), by striking ''and before April 1, 2014,''; and

(ii) in clause (iv), by striking ''through fiscal year 2013 and the portion of fiscal year 2014 before April 1, 2014'' and inserting ''or a subsequent fiscal year''.

(B) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—Section 1886(o)(7)(D)(ii)(I) of the Social Security Act (42 U.S.C. 1395ww(o)(7)(D)(ii)(I)) is amended by striking ''(with respect to discharges occurring during fiscal year 2012 and 2013)''.

(C) HOSPITAL READMISSION REDUCTION PROGRAM.—Section 1886(q)(2)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(q)(2)(B)(i)) is amended by striking ''(with respect to discharges occurring during fiscal years 2012 and 2013)''.

(D) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of

the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''fiscal year 1998, fiscal year 1999, or fiscal year 2000 through the first 2 quarters of fiscal year 2014'' and inserting ''or fiscal year 1998 or a subsequent fiscal year''.

(b) GAO STUDY AND REPORT ON MEDICARE-DEPENDENT HOSPITALS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the following:

(A) The payor mix of medicare-dependent, small rural hospitals (as defined in section 1886(d)(5)(G)(iv)), how such mix will trend in future years, and whether or not the requirement under subclause (IV) of such section should be revised.

(B) The characteristics of medicare-dependent, small rural hospitals that meet the requirement of such subclause (IV) through the application of paragraph (a)(iii)(A) or (a)(iii)(B) of section 412.108 of the Code of Federal Regulations, including Medicare inpatient and outpatient utilization, payor mix, and financial status, including Medicare and total

margins, and whether or not Medicare payments for such hospitals should be revised.

(C) Such other items related to medicare-dependent, small rural hospitals as the Comptroller General determines appropriate.

(2) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, for purposes of fiscal year 2014, the Secretary of Health and Human Services may implement the provisions of, and the amendments made by, this section through program instruction or otherwise.

**SEC. 205. REVISION OF MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.**

(a) IN GENERAL.—Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B)—

(A) in the subparagraph heading, by inserting ''FOR FISCAL YEARS 2005 THROUGH 2010'' after ''INCREASE''; and

(B) in the matter preceding clause (i), by striking ''and for discharges occurring in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent years'';

(2) in subparagraph (C)(i)—

(A) by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before'' and inserting ''fiscal year 2011 and subsequent fiscal years,'' each place it appears; and

(B) by striking ''or portion of fiscal year'' after ''during the fiscal year''; and

(3) in subparagraph (D)—

(A) in the heading, by striking ''TEMPORARY APPLICABLE PERCENTAGE INCREASE'' and inserting ''APPLICABLE PERCENTAGE INCREASE FOR FISCAL YEAR 2011 AND SUBSEQUENT FISCAL YEARS'';

(B) by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014

before April 1, 2014'' and inserting ''fiscal year 2011 or a subsequent fiscal year''; and

(C) by striking ''or the portion of fiscal year'' after ''in the fiscal year''.

(b) IMPLEMENTATION.—Notwithstanding any other provision of law, for purposes of fiscal year 2014, the Secretary of Health and Human Services may implement the provisions of, and the amendments made by, this section through program instruction or otherwise.

**SEC. 206. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.**

(a) EXTENSION.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended—

(1) by striking ''ENROLLMENT.—In the case'' and inserting ''ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case'';

(2) in subparagraph (A), as added by paragraph (1), by striking ''and for periods before January 1, 2016''; and

(3) by adding at the end the following new subparagraphs:

''(B) APPLICATION TO DUAL SNPS.—Subparagraph (A) shall only apply to a specialized MA plan for special needs individuals described

in subsection (b)(6)(B)(ii) for periods before January 1, 2021.

''(C) APPLICATION TO SEVERE OR DISABLING CHRONIC CONDITION SNPS.—Subparagraph (A) shall only apply to a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii) for periods before January 1, 2018.''.

(b) INCREASED INTEGRATION OF DUAL SNPS.—

(1) IN GENERAL.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended—

(A) in paragraph (3), by adding at the end the following new subparagraph:

''(F) The plan meets the requirements applicable under paragraph (8).''; and

(B) by adding at the end the following new paragraph:

''(8) INCREASED INTEGRATION OF DUAL SNPS.—

''(A) DESIGNATED CONTACT.—The Secretary, acting through the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) established under section 2602 of the Patient Protection and Affordable Care Act (in this paragraph referred to as the 'MMCO'),

shall serve as a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this paragraph. Consistent with such role, the MMCO shall—

''(i) establish a uniform process for disseminating to State Medicaid agencies information under this title impacting contracts between such agencies and such plans under this subsection; and

''(ii) establish basic resources for States interested in exploring such plans as a platform for integration.

''(B) UNIFIED GRIEVANCES AND APPEALS PROCESS.—

''(i) IN GENERAL.—Not later than April 1, 2015, the Secretary shall establish procedures unifying the grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), and 1902(a)(5) for items and services provided by specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) under this title and title XIX. The Secretary

shall solicit comment in developing such procedures from States, plans, beneficiary representatives, and other relevant stakeholders.

''(ii) PROCEDURES.—The procedures established under clause (i) shall—

''(I) adopt the most protective provisions for the enrollee under current law, including continuation of benefits under title XIX pending appeal if an appeal is filed in a timely manner;

''(II) take into account differences in State plans under title XIX;

''(III) be easily navigable by an enrollee; and

''(IV) include the elements described in clause (iii).

''(iii) ELEMENTS DESCRIBED.—The following elements are described in this clause:

''(I) Single notification of all applicable grievances and appeal rights under this title and title XIX.

''(II) Notices written in plain language and available in a language and format that is accessible to the enrollee.

''(III) Unified timeframes for internal and external grievances and appeals processes, such as an individual's filing of a grievance or appeal, a plan's acknowledgment and resolution of a grievance or appeal, and notification of decisions with respect to a grievance or appeal.

''(IV) Guidelines to allow the plan to process, track, and resolve grievances and appeals, to ensure beneficiaries are notified on a timely basis of decisions that are made throughout the grievance or appeals process and are able to easily determine the status of a grievance or appeal.

''(C) REQUIREMENT FOR UNIFIED GRIEVANCES AND APPEALS.—

''(i) IN GENERAL.—For 2016 and subsequent years, the contract of a special-

ized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) with a State Medicaid agency under this subsection shall require the use of unified grievances and appeals procedures as described in subparagraph (B).

''(ii) CONSIDERATION OF APPLICATION FOR OTHER SNPS.—The Secretary shall consider applying the unified grievances and appeals process described in subparagraph (B) to specialized MA plans for special needs individuals described in subsection (b)(6)(B)(i) and subsection (b)(6)(B)(iii) that have a substantial portion of enrollees who are dually eligible for benefits under this title and title XIX and are at risk for full benefits under title XIX.

''(D) REQUIREMENT FOR FULL INTEGRATION FOR CERTAIN DUAL SNPS.—

''(i) REQUIREMENT.—Subject to the succeeding provisions of this subparagraph, for 2018 and subsequent years, a specialized MA plan for special needs individuals

described in subsection (b)(6)(B)(ii) shall—

"(I) integrate all benefits under this title and title XIX; and

"(II) meet the requirements of a fully integrated plan described in section 1853(a)(1)(B)(iv)(II) (other than the requirement that the plan have similar average levels of frailty, as determined by the Secretary, as the PACE program), including with respect to long-term care services or behavioral health services to the extent State law permits capitation of those services under such plan.

"(ii) INITIAL SANCTIONS FOR FAILURE TO MEET REQUIREMENT FOR 2018 OR 2019.—For each of 2018 and 2019, if the Secretary determines that a plan has failed to meet the requirement described in clause (i), the Secretary shall impose one of the following on the plan:

"(I) A reduction in payment to the plan under this part in an amount at least equal to the portion of the

monthly rebate computed under section 1854(b)(1)(C)(i) for the plan and year that would otherwise be kept by the plan after application of the beneficiary rebate rule under section 1854(b)(1)(C).

''(II) Closing enrollment in the plan.

''(III) Sanctioning the plan in accordance with section 1857(g).

''(IV) Other reasonable action (other than the sanction described in clause (iii)) the Secretary determines appropriate.

''(iii) SANCTIONS FOR FAILURE TO MEET REQUIREMENT FOR 2020 AND SUBSEQUENT YEARS.—For 2020 and subsequent years, if the Secretary determines that a plan has failed to meet the requirement described in clause (i), the plan shall be deemed to no longer meet the definition of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii).

''(iv) LIMITATION.—This subparagraph shall not apply to a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) that only enrolls individuals for whom the only medical assistance to which the individuals are entitled under the State plan is medicare cost sharing described in section 1905(p)(3)(A)(ii).''.

(2) CONFORMING AMENDMENT TO RESPONSIBILITIES OF FEDERAL COORDINATED HEALTH CARE OFFICE (MMCO).—Section 2602(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 1315b(d)) is amended by adding at the end the following new paragraph:

''(6) To act as a designated contact for States under subsection (f)(8)(A) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) with respect to the integration of specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of such section.''.

(c) IMPROVEMENTS TO SEVERE OR DISABLING CHRONIC CONDITION SNPS.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended—

(1) by striking ''ALL SNPS.—The requirements'' and inserting ''ALL SNPS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the requirements'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately;

(3) in clause (ii), as redesignated by paragraph (2), by redesignating clauses (i) through (iii) as subclauses (I) through (III), respectively, and indenting appropriately; and

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

''(B) IMPROVEMENTS TO CARE MANAGEMENT REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—For 2016 and subsequent years, in the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the requirements described in this paragraph include the following:

''(i) The interdisciplinary team under subparagraph (A)(ii)(III) includes a team of providers with demonstrated expertise, including training in an applicable spe-

cialty, in treating individuals similar to the targeted population of the plan.

''(ii) Requirements developed by the Secretary to provide face-to-face encounters with individuals enrolled in the plan not less frequently than on an annual basis.

''(iii) As part of the model of care under clause (i) of subparagraph (A), the results of the initial assessment and annual reassessment under clause (ii)(I) of such subparagraph of each individual enrolled in the plan are addressed in the individual's individualized care plan under clause (ii)(II) of such subparagraph.

''(iv) As part of the annual evaluation and approval of such model of care, the Secretary shall take into account whether the plan fulfilled the previous year's goals (as required under the model of care).

''(v) The Secretary shall establish a minimum benchmark for each element of the model of care of a plan. The Secretary shall only approve a plan's model of care under this paragraph if each element of

the model of care meets the minimum benchmark applicable under the preceding sentence.''.

(d) GAO STUDY ON QUALITY IMPROVEMENT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on how the Secretary of Health and Human Services could change the quality measurement system under the Medicare Advantage program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) to allow an accurate comparison of the quality of care provided by specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of such Act (42 U.S.C. 1395w–28(b)(6)), both for individual plans and such plans overall, compared to the quality of care delivered by the original Medicare fee-for-service program under parts A and B of such title and other Medicare Advantage plans under such part C across similar populations.

(2) REPORT.—Not later than July 1, 2016, the Comptroller General shall submit to Congress a report containing the results of the study under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(e) CHANGES TO QUALITY RATINGS AND MEASUREMENT OF SNPS AND DETERMINATION OF FEASABILITY OF QUALITY MEASUREMENT AT THE PLAN LEVEL.—Section 1853(o) of the Social Security Act (42 U.S.C. 1395w–23(o)) is amended by adding at the end the following new paragraphs:

"(6) CHANGES TO QUALITY RATINGS OF SNPS.—

"(A) EMPHASIS ON IMPROVEMENT ACROSS SNPS.—Subject to subparagraph (B), beginning in plan year 2016, in the case of a specialized MA plan for special needs individuals, the Secretary shall increase the emphasis on the plan's improvement or decline in performance when determining the star rating of the plan under this subsection for the year as follows:

"(i)(I) For plan year 2016, at least 10 percent, but not more than 12 percent, of the total star rating of the plan shall be based on improvement or decline in performance.

"(II) For plan year 2017 and subsequent plan years, at least 12 percent, but not more than 15 percent, of the total star

rating of the plan shall be based on improvement or decline in performance.

''(ii) Improvement or decline in performance under this subparagraph shall be measured based on net change in the individual star rating measures of the plan, with appropriate weight given to specific individual star ratings measures, such as readmission rates, as determined by the Secretary.

''(iii) The Secretary shall make an appropriate adjustment to the improvement rating of a plan under this subparagraph if the plan has achieved a 4.5-star rating or the highest rating possible overall or for an individual measure in order to ensure that the plan is not punished in cases where it is not possible to improve.

''(B) NO APPLICATION TO CERTAIN PLANS.—Subparagraph (A) shall not apply, with respect to a year, to a specialized MA plan for special needs individuals that has a rating that is less than two-and-one-half stars.

''(C) QUALITY MEASUREMENT AT THE PLAN LEVEL.—

"(i) IN GENERAL.—The Secretary may require reporting for and apply under this subsection quality measures at the plan level for specialized MA plan for special needs individuals instead of at the contract level.

"(ii) CONSIDERATION.—The Secretary shall take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under clause (i).

"(iii) APPLICATION.—If the Secretary applies quality measurement at the plan level under this subparagraph—

"(I) such quality measurement shall include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures; and

"(II) payment and other administrative actions linked to quality meas-

urement (including the 5-star rating system under this subsection) shall be applied at the plan level in accordance with this subparagraph.

''(7) DETERMINATION OF FEASIBILITY OF QUALITY MEASUREMENT AT THE PLAN LEVEL.—

''(A) DETERMINATION OF FEASIBILITY.—The Secretary shall determine the feasibility of requiring reporting for and applying under this subsection quality measures at the plan level for all MA plans under this part.

''(B) CONSIDERATION OF CHANGE.—After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph.''.

**SEC. 207. REASONABLE COST REIMBURSEMENT CONTRACTS.**

(a) ONE-YEAR TRANSITION AND NOTICE REGARDING TRANSITION.—Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(1) in clause (ii), in the matter preceding subclause (I), by striking ''For any'' and inserting ''Subject to clause (iv), for any''; and

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

''(iv) In the case of an eligible organization that is offering a reasonable cost reimbursement contract that may no longer be extended or renewed because of the application of clause (ii), the following shall apply:

''(I) Notwithstanding such clause, such contract may be extended or renewed for the two years subsequent to the previous year described in clause (ii). The second of the two years described in the preceding sentence with respect to a contract is referred to in this subsection as the 'last reasonable cost reimbursement contract year for the contract'.

''(II) The organization may not enroll any new enrollees under such contract during the last reasonable cost reimbursement contract year for the contract.

''(III) Not later than a date determined appropriate by the Secretary prior to the beginning of the last reasonable cost reimbursement contract year for the contract, the organization shall provide notice to the Secretary as to whether or not the organization will apply to have the contract converted over and offered as a Medicare Advantage plan under part C

for the year following the last reasonable cost reimbursement contract year for the contract.

''(IV) If the organization provides the notice described in subclause (III) that the contract will be converted, the organization shall, not later than a date determined appropriate by the Secretary, provide the Secretary with such information as the Secretary determines appropriate in order to carry out sections 1851(c)(4) and 1854(a)(5), including subparagraph (C) of such section.

''(v) If an eligible organization that is offering a reasonable cost reimbursement contract that is extended or renewed pursuant to clause (iv) provides the notice described in clause (iv)(III) that the contract will be converted, the following provisions shall apply:

''(I) The deemed enrollment under section 1851(c)(4).

''(II) The special rule for quality increases under 1853(o)(3)(A)(iv).''.

(b) DEEMED ENROLLMENT FROM REASONABLE COST REIMBURSEMENT CONTRACTS CONVERTED TO MEDICARE ADVANTAGE PLANS.—

(1) IN GENERAL.—Section 1851(c) of the Social Security Act (42 U.S.C. 1395w–21(c)) is amended—

(A) in paragraph (1), by striking ''Such elections'' and inserting ''Subject to paragraph (4), such elections''; and

(B) by adding at the end the following:

''(4) DEEMED ENROLLMENT RELATING TO CONVERTED REASONABLE COST REIMBURSEMENT CONTRACTS.—

''(A) IN GENERAL.—On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under this title through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

''(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year;

''(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract pursuant to section 1876(h)(5)(C)(iv);

''(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

''(iv) the applicable MA plan—

''(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

''(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

''(III) is offered in the service area where the individual resides;

''(v) the applicable MA plan provides benefits, premiums, and access to in-network and out-of-network providers that are comparable to the benefits, premiums, and access to in-network and out-of-network providers under such reasonable cost reimbursement contract for the previous plan year; and

"(vi) the applicable MA plan—

"(I) allows enrollees transitioning from the converted reasonable cost contract to such plan to maintain current providers and course of treatment at the time of enrollment for at least 90 days after enrollment; and

"(II) during such period, pays non-contracting providers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for those items and services under the original medicare fee-for-service program under parts A and B.

"(B) MA ELIGIBLE INDIVIDUALS DESCRIBED.—

"(i) WITHOUT PRESCRIPTION DRUG COVERAGE.—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who does not, for such previous plan year, receive any pre-

scription drug coverage under part D, including coverage under section 1860D–22.

''(ii) WITH PRESCRIPTION DRUG COVERAGE.—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who, for such previous plan year, receives prescription drug coverage under part D—

''(I) through such contract; or

''(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

''(C) APPLICABLE MA PLAN DEFINED.—In this paragraph, the term 'applicable MA plan' means, in the case of an individual described in—

''(i) subparagraph (B)(i), an MA plan that is not an MA–PD plan; and

''(ii) subparagraph (B)(ii), an MA–PD plan.

''(D) IDENTIFICATION AND NOTIFICATION OF DEEMED INDIVIDUALS.—Not later than 30 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.''.

(2) BENEFICIARY OPTION TO DISCONTINUE OR CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED ENROLLMENT.—

(A) IN GENERAL.—Section 1851(e)(2) of the Social Security Act (42 U.S.C. 1395w–21(e)(4)) is amended by adding at the end the following:

''(F) SPECIAL PERIOD FOR CERTAIN DEEMED ELECTIONS.—

''(i) IN GENERAL.—At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of Feb-

ruary of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

''(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).''.

(B) CONFORMING AMENDMENTS.—

(i) PLAN REQUIREMENT FOR OPEN ENROLLMENT.—Section 1851(e)(6)(A) of the Social Security Act (42 U.S.C. 1395w–21(e)(6)(A)) is amended by striking ''paragraph (1),'' and inserting ''paragraph (1), during the period described in paragraph (2)(F),''.

(ii) PART D.—Section 1860D–1(b)(1)(B) of such Act (42 U.S.C. 1395w–101(b)(1)(B)) is amended—

(I) in clause (ii), by adding ''and paragraph (4)'' after ''paragraph (3)(A)''; and

(II) in clause (iii) by striking ''and (E)'' and inserting ''(E), and (F)''.

(3) TREATMENT OF ESRD FOR DEEMED ENROLLMENT.—Section 1851(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)(B)) is amended by adding at the end the following flush sentence:

''An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1876(h) shall be treated as an MA eligible individual for purposes of applying the deemed enrollment under subsection (c)(4).''.

(c) INFORMATION REQUIREMENTS.—Section 1851(d)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(d)(2)(B)) is amended—

(1) by striking the subparagraph heading and inserting the following: ''(i) NOTIFICATION TO

NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE INDIVIDUALS.—''; and

(2) by adding at the end the following:

''(ii) NOTIFICATION RELATED TO CERTAIN DEEMED ELECTIONS.—The Secretary shall require the converting cost plan to mail, not later than 15 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual identified by the Secretary under subsection (c)(4)(D) for such year—

''(I) a notification that such individual will, on such day, be deemed to have made an election to receive benefits under this title through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

''(II) the information described in subparagraph (A);

''(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement

contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

''(IV) information about the special period for elections under subsection (e)(2)(F); and

''(V) other information the Secretary may specify''.

(d) TREATMENT OF TRANSITION PLAN FOR QUALITY RATING FOR PAYMENT PURPOSES.—Section 1853(o)(4) of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR FIRST 3 PLAN YEARS FOR PLANS THAT WERE CONVERTED FROM A REASONABLE COST REIMBURSEMENT CONTRACT.—For purposes of applying paragraph (1) and section 1854(b)(1)(C) for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1851(c)(4)—

''(i) such plan shall not be treated as a new plan (as defined in paragraph (3)(A)(iii)(II)); and

''(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.''.

**SEC. 208. QUALITY MEASURE ENDORSEMENT AND SELECTION.**

(a) CONTRACT WITH AN ENTITY REGARDING INPUT ON THE SELECTION OF MEASURES.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(A) by redesignating section 1890A as section 1890B; and

(B) by inserting after section 1890 the following new section:

''CONTRACT WITH AN ENTITY REGARDING INPUT ON THE SELECTION OF MEASURES

''SEC. 1890A (a) CONTRACT.—

''(1) IN GENERAL.—For purposes of activities conducted under this Act, the Secretary shall iden-

tify and have in effect a contract with an entity that meets the requirements described in subsection (c). Such contract shall provide that the entity will perform the duties described in subsection (b).

''(2) TIMING FOR FIRST CONTRACT.—The first contract under paragraph (1) shall begin on, or as soon as practicable after, October 1, 2014.

''(3) PERIOD OF CONTRACT.—A contract under paragraph (1) shall be for a period of 3 years (except as may be renewed after a subsequent bidding process).

''(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under paragraph (1).

''(b) DUTIES.—The duties described in this subsection are the following:

''(c) REQUIREMENTS DESCRIBED.—The requirements described in this subsection are the following:

''(1) PRIVATE NONPROFIT, BOARD MEMBERSHIP, MEMBERSHIP FEES, AND NOT A MEASURE DEVELOPER.—The requirements described in paragraphs (1), (2), (7), and (8) of section 1890(c).

''(2) EXPERIENCE.—The entity has at least 4 years of experience working with quality and efficiency measures.''.

(2) DUTIES OF ENTITY.—

(A) TRANSFER OF PRIORITY SETTING PROCESS.—Paragraph (1) of section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is redesignated as paragraph (1) of section 1890A(b) of such Act, as added by paragraph (1).

(B) TRANSFER OF MULTI-STAKEHOLDER PROCESS.—Paragraphs (7) and (8) of such section 1890(b) are redesignated as paragraphs (2) and (3), respectively, of section 1890A(b) of such Act, as added by paragraph (1) and amended by subparagraph (A).

(C) ADDITIONAL DUTIES.—Section 1890A(b) of such Act, as added by paragraph (1) and amended by subparagraphs (A) and (B), is amended by adding at the end the following new paragraphs:

''(4) FACILITATION TO BETTER COORDINATE AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF QUALITY MEASURES.—

''(A) IN GENERAL.—The entity shall facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

''(B) REPORTS.—The entity shall prepare and make available to the public annual reports on its findings under this paragraph. Such public availability shall include posting each report on the Internet website of the entity.

''(5) GAP ANALYSIS.—The entity shall conduct an ongoing analysis of—

''(A) gaps in endorsed quality and efficiency measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act; and

''(B) areas where quality measures are unavailable or inadequate to identify or address such gaps.

''(6) ANNUAL REPORT TO CONGRESS AND THE SECRETARY; SECRETARIAL PUBLICATION AND COMMENT.—

''(A) ANNUAL REPORT.—By not later than June 1 of each year, the entity shall submit to

Congress and the Secretary a report containing—

''(i) a description of—

''(I) the recommendations made under paragraph (1);

''(II) the matters described in clauses (i) and (ii) of paragraph (2)(A);

''(III) the results of the analysis under paragraph (5); and

''(IV) the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a); and

''(ii) any other items determined appropriate by the Secretary.

''(B) SECRETARIAL REVIEW AND PUBLICATION OF ANNUAL REPORT.—Not later than 6 months after receiving a report under subparagraph (A), the Secretary shall—

''(i) review such report; and

''(ii) publish such report in the Federal Register, together with any comments of the Secretary on such report.''.

(D) ADDITIONAL AMENDMENTS.—Section 1890A(b) of such Act, as so added and amended, is amended—

(i) in paragraph (2)—

(I) in subparagraph (A)(i)—

(aa) in subclause (I), by inserting ''with a contract under section 1890'' after ''entity''; and

(bb) in subclause (II), by striking ''such entity'' and inserting ''the entity with a contract under section 1890'';

(II) in the heading of subparagraph (B) by inserting ''AND EFFICIENCY'' after ''QUALITY'';

(III) in subparagraph (B)(i)(III), by striking ''this Act'' and inserting ''this title''; and

(IV) by adding at the end the following new subparagraphs:

''(E) INPUT.—In providing the input described in subparagraph (A), the multi-stakeholder groups—

''(i) shall include a detailed description of the rationale for each recommenda-

tion made by the multi-stakeholder group, including in areas relating to—

"(I) the expected impact that implementing the measure will have on individuals;

"(II) the burden on providers of services and suppliers;

"(III) the expected influence over the behavior of providers of services and suppliers;

"(IV) the applicability of a measure for more than one setting or program; and

"(V) other areas determined in consultation with the Secretary; and

"(ii) may consider whether it is appropriate to provide separate recommendations with respect to measures for internal use, public reporting, and payment provisions.

"(F) EQUAL REPRESENTATION.—In convening multi-stakeholder groups pursuant to this paragraph, the entity shall, to the extent feasible, make every effort to ensure such groups are balanced across stakeholders."; and

(ii) in paragraph (3), by striking ''Not later'' and all that follows through the period at the end and inserting the following: ''Not later than the applicable dates described in section 1890B(a)(3) of each year (or, as applicable, the timeframe described in section 1890B(a)(4)), the entity shall transmit to the Secretary the input of the multi-stakeholder groups under paragraph (2).''.

(b) REVISIONS TO CONTRACT WITH CONSENSUS-BASED ENTITY.—

(1) CONTRACT.—Section 1890(a) of the Social Security Act (42 U.S.C. 1395aaa(a)) is amended—

(A) in paragraph (1), by striking '', such as the National Quality Forum,''; and

(B) in paragraph (3), by striking ''4 years'' and inserting ''3 years''.

(2) DUTIES.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)), as amended by subsection (a)(2), is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively;

(B) in paragraph (2), as redesignated by subparagraph (A), by striking ''paragraph (2)'' and inserting ''paragraph (1)'';

(C) by striking paragraphs (5) and (6); and

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

''(3) FACILITATION TO BETTER COORDINATE AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF QUALITY MEASURES.—

''(A) IN GENERAL.—The entity shall facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

''(B) REPORTS.—The entity shall prepare and make available to the public annual reports on its findings under this paragraph. Such public availability shall include posting each report on the Internet website of the entity.

''(4) ANNUAL REPORT TO CONGRESS AND THE SECRETARY; SECRETARIAL PUBLICATION AND COMMENT.—

''(A) ANNUAL REPORT.—By not later than March 1 of each year, the entity shall submit

to Congress and the Secretary a report containing—

"(i) a description of—

"(I) the coordination of quality initiatives under this title and titles XIX and XXI with quality initiatives implemented by other payers;

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

"(III) the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a); and

"(ii) any other items determined appropriate by the Secretary.

"(B) SECRETARIAL REVIEW AND PUBLICATION OF ANNUAL REPORT.—Not later than 6 months after receiving a report under subparagraph (A), the Secretary shall—

''(i) review such report; and

''(ii) publish such report in the Federal Register, together with any comments of the Secretary on such report.''.

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

''(8) NOT A MEASURE DEVELOPER.—The entity is not a measure developer.''.

(c) REVISIONS TO DUTIES OF THE SECRETARY REGARDING USE OF MEASURES.—

(1) IN GENERAL.—Section 1890B(a) of the Social Security Act (42 U.S.C. 1395aaa–1(a)), as redesignated by subsection (a)(1)(A), is amended—

(A) by striking ''section 1890(b)(7)(B)'' each place it appears and inserting ''section 1890A(b)(2)(B)'';

(B) in paragraph (1)—

(i) by striking ''section 1890(b)(7)'' and inserting ''section 1890A(b)(2)''; and

(ii) by striking ''section 1890'' and inserting ''section 1890A'';

(C) by striking paragraphs (2) and (3) and inserting the following:

''(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Subject to paragraph (4), not later than October 1 or December 31 of each year (or as soon as practicable after such dates for the first year of the contract), the Secretary shall make available to the public a list of quality and efficiency measures described in section 1890A(b)(2)(B) that the Secretary is considering under this title. The Secretary shall provide for an appropriate balance of the number of measures to be made available by each such date in a year.

''(3) TRANSMISSION OF MULTI-STAKEHOLDER INPUT.—

''(A) IN GENERAL.—Subject to paragraph (4), not later than the applicable date described in subparagraph (B) of each year, the entity with a contract under section 1890A shall, pursuant to subsection (b)(3) of such section, transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

''(B) APPLICABLE DATE DESCRIBED.—The applicable date described in this subparagraph for a year is—

''(i) February 1 (or as soon as practicable after such date for the first year of

the contract) with respect to quality and efficiency measures made available under paragraph (2) by October 1 of the preceding year; and

''(ii) April 1 (or as soon as practicable after such dates for the first year of the contract) with respect to quality and efficiency measures made available under paragraph (2) by December 31 of the preceding year.'';

(D) by redesignating—

(i) paragraph (6) as paragraph (8); and

(ii) paragraphs (4) and (5) as paragraphs (5) and (6), respectively;

(E) by inserting after paragraph (3) the following new paragraph:

''(4) LIMITED PROCESS FOR ADDITIONAL MULTI-STAKEHOLDER INPUT.—In addition to the Secretary making measures publically available pursuant to the dates described in paragraph (2) and multi-stakeholder groups transmitting the input pursuant to the applicable dates described in paragraph (3)—

''(A) the Secretary may, at times that do not meet the time requirements described in paragraph (2), make available to the public a limited number of quality and efficiency measures described in section 1890A(b)(2) that the Secretary is considering under this title; and

''(B) if the Secretary uses the authority under subparagraph (A), the entity with a contract under section 1890A shall, pursuant to section 1890A(b)(3), transmit to the Secretary on a timely basis the input from a multi-stakeholder group described in paragraph (1) with respect to such measures.'';

(F) in paragraph (6), as redesignated by subparagraph (D)(ii), by inserting ''or that has not been recommended by the multi-stakeholder group under section 1890A(b)(2)'' before the period at the end; and

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

''(7) CONCORDANCE RATES.—For each year (beginning with 2015), the Secretary shall include a list of concordance rates with respect to the input provided under section 1890A(b)(2)(A) for those new measures adopted for each type of provider of

services and supplier in the annual final rule applicable to such type of provider or supplier.''.

(2) REVIEW.—Section 1890B(c) of the Social Security Act (42 U.S.C. 1395aaa–1(c)), as redesignated by subsection (a)(1)(A), is amended—

(A) in paragraph (1)(A), by striking ''section 1890(b)(7)(B)'' and inserting ''section 1890A(b)(2)(B)''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''and'' at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

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

''(C) take into consideration the benefits of the alignment of measures between the public and private sector.''.

(d) FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION.—

(1) FISCAL YEAR 2014.—In addition to amounts transferred under section 3014(c) of the Patient Protection and Affordable Care Act (Public Law 111–148), for purposes of carrying out section 1890

and section 1890A (other than subsections (e) and (f)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, to the Centers for Medicare & Medicaid Services Program Management Account of $7,000,000 for fiscal year 2014. Amounts transferred under the preceding sentence shall remain available until expended.

(2) FISCAL YEARS 2015 THROUGH 2017.—Section 1890B of the Social Security Act (42 U.S.C. 1395aaa–1), as redesignated by subsection (a)(1)(A), is amended by adding at the end the following new subsection:

''(g) FUNDING.—

''(1) IN GENERAL.—For purposes of carrying out this section (other than subsections (e) and (f)) and sections 1890 and 1890A, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, to the Centers for

Medicare & Medicaid Services Program Management Account of $25,000,000 for each of fiscal years 2015 through 2017.

''(2) AVAILABILITY.—Amounts transferred under paragraph (1) shall remain available until expended.''.

(3) CONFORMING AMENDMENT.—Subsection (d) of section 1890 of the Social Security Act (42 U.S.C. 1395aaa) is repealed.

(e) CONFORMING AMENDMENTS.—(1) Section 1848(m)(3)(E)(iii) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)(iii)) is amended by striking ''section 1890(b)(7) and 1890A(a)'' and inserting ''section 1890A(b)(2) and 1890B(a)''.

(2) Section 1866D(b)(2)(C) of the Social Security Act (42 U.S.C. 1395cc–4(b)(2)(C)) is amended by striking ''section 1890 and 1890A'' and inserting ''sections 1890, 1890A, and 1890B''.

(3) Section 1899A(n)(2)(A) of the Social Security Act (42 U.S.C. 1395cc–4(n)(2)(A)) is amended by striking ''section 1890(b)(7)(B)'' and inserting ''section 1890A(b)(2)(B)''.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on October 1, 2014,

and shall apply with respect to contract periods under sections 1890 and 1890A of the Social Security Act that begin on or after such date.

(2) NEW CONTRACTS.—The Secretary of Health and Human Services shall enter into a new contract under both sections 1890 and 1890A of the Social Security Act, as amended by this Act, for a contract period beginning on, or as soon as practicable after, October 1, 2014.

**SEC. 209. PERMANENT EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.**

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B)(iv) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act (Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), and section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), is amended to read as follows:

"(iv) for fiscal year 2014 and for each subsequent fiscal year, $7,500,000.".

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B)(iv) of such section 119, as so amended, is amended to read as follows:

"(iv) for fiscal year 2014 and for each subsequent fiscal year, $7,500,000.".

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B)(iv) of such section 119, as so amended, is amended to read as follows:

"(iv) for fiscal year 2014 and for each subsequent fiscal year, $5,000,000.".

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2)(iv) of such section 119, as so amended, is amended to read as follows:

"(iv) for fiscal year 2014 and for each subsequent fiscal year, $5,000,000.".

# Subtitle B—Medicaid and Other Extensions

**SEC. 211. QUALIFYING INDIVIDUAL PROGRAM.**

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking "March 2104" and inserting "December 2018".

(b) ELIMINATING LIMITATIONS ON ELIGIBILITY.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended by striking subsections (b) and (e).

(c) ELIMINATING ALLOCATIONS.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended by striking subsections (c) and (g).

(d) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3), as amended by subsections (b) and (c), is further amended—

(A) by striking subsection (a) and inserting the following new subsection:

''(a) APPLICABLE FMAP.—With respect to assistance described in section 1902(a)(10)(E)(iv) furnished in a State, the Federal medical assistance percentage shall be equal to 100 percent.'';

(B) by striking subsection (d); and

(C) by redesignating subsection (f) as subsection (b).

(2) DEFINITION OF FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''section 1933(d)'' and inserting ''section 1933(a)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on April 1, 2014, and shall

apply with respect to calendar quarters beginning on or after such date.

**SEC. 212. TRANSITIONAL MEDICAL ASSISTANCE.**

(a) EXTENSION.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''March 31, 2014'' and inserting ''December 31, 2018''.

(b) OPT-OUT OPTION FOR STATES THAT EXPAND ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS ELIGIBILITY UNDER MEDICAID AND CHIP.—

(1) IN GENERAL.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6), as amended by subsection (a), is further amended—

(A) in subsection (a)—

(i) in paragraph (1)(A), by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

(ii) by adding at the end the following:

''(6) OPT-OUT OPTION FOR STATES THAT EXPAND ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS ELIGIBILITY UNDER MEDICAID AND CHIP.—

''(A) IN GENERAL.—In the case of a State described in subparagraph (B), the State may elect through a State plan amendment to have this section and sections 408(a)(11)(A), 1902(a)(52), 1902(e)(1), and 1931(c)(2) not apply to the State.

''(B) STATE DESCRIBED.—A State is described in this subparagraph if the State is one of the 50 States or the District of Columbia and—

''(i) has elected to provide medical assistance to individuals under subclause (VIII) of section 1902(a)(10)(A)(i);

''(ii) has elected under section 1902(e)(12)(A) the option to provide continuous eligibility for a 12-month period for individuals under 19 years of age;

''(iii) has elected under section 1902(e)(12)(B) the option to provide continuous eligibility for a 12-month period for all categories of individuals described in that section; and

''(iv) has elected to apply section 1902(e)(12)(A) to the State child health plan under title XXI.''; and

(B) in subsection (b)(1), by striking ''subsection (a)(5)'' and inserting ''paragraphs (5) and (6) of subsection (a)''.

(2) CONFORMING AMENDMENT TO 4-MONTH REQUIREMENT.—Section 1902(e)(1) of the Social Security Act (42 U.S.C. 1396a(e)(1)), as amended by subsection (a), is further amended—

(A) in subparagraph (B), by striking ''Subparagraph (A)'' and inserting ''Subject to subparagraph (C), subparagraph (A)''; and

(B) by adding at the end the following:

''(C) If a State has made an election under section 1925(a)(6), subparagraph (A) and section 1925 shall not apply to the State.''.

(c) EXTENSION OF 12-MONTH CONTINUOUS ELIGIBILITY OPTION TO CERTAIN ADULT ENROLLEES UNDER MEDICAID; CLARIFICATION OF APPLICATION TO CHIP.—

(1) IN GENERAL.—Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(B) by inserting ''(A)'' after ''(12)''; and

(C) by adding at the end the following:

''(B) At the option of the State, the plan may provide that an individual who is determined to be eligible for benefits under a State plan approved under this title under any of the following eligibility categories, or who is redetermined to be eligible for such benefits under any of such categories, shall be considered to meet the eligibility requirements met on the date of application and shall remain eligible for those benefits until the end of the 12–month period following the date of the determination or redetermination of eligibility:

''(i) Section 1902(a)(10)(A)(i)(VIII).

''(ii) Section 1931.''.

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (E) through (O) as subparagraphs (F) through (P), respectively; and

(B) by inserting after subparagraph (D), the following:

''(E) Section 1902(e)(12)(A) (relating to the State option for 12-month continuous eligibility and enrollment).''.

(d) CONFORMING AND TECHNICAL AMENDMENTS RELATING TO SECTION 1931 TRANSITIONAL COVERAGE REQUIREMENTS.—

(1) IN GENERAL.—Section 1931(c) of the Social Security Act (42 U.S.C. 1396u–1(c)) is amended—

(A) in paragraph (1)—

(i) in the paragraph heading, by striking ''CHILD'' and inserting ''SPOUSAL'';

(ii) by striking ''The provisions'' and inserting ''Subject to paragraph (3), the provisions''; and

(iii) by striking ''child or'';

(B) in paragraph (2), by striking ''For continued'' and inserting ''Subject to paragraph (3), for continued''; and

(C) by adding at the end the following:

''(3) OPT-OUT OPTION FOR STATES THAT EXPAND ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS ELIGIBILITY UNDER MEDICAID AND CHIP.—

''(A) IN GENERAL.—In the case of a State described in subparagraph (B), the State may elect through a State plan amendment to have paragraphs (1) and (2) of this subsection and

sections 408(a)(11), 1902(a)(52), 1902(e)(1), and 1925 not apply to the State.

''(B) STATE DESCRIBED.—A State is described in this subparagraph if the State is one of the 50 States or the District of Columbia and—

''(i) has elected to provide medical assistance to individuals under subclause (VIII) of section 1902(a)(10)(A)(i);

''(ii) has elected under section 1902(e)(12)(A) the option to provide continuous eligibility for a 12-month period for individuals under 19 years of age;

''(iii) has elected under section 1902(e)(12)(B) the option to provide continuous eligibility for a 12-month period for all categories of individuals described in that section; and

''(iv) has elected to apply section 1902(e)(12)(A) to the State child health plan under title XXI.''.

(2) CONFORMING AMENDMENT TO SECTION 408.—Section 408(a)(11) of the Social Security Act (42 U.S.C. 608(a)(11) is amended—

(A) in the paragraph heading, by striking ''CHILD'' and inserting ''SPOUSAL''; and

(B) in subparagraph (B)—

(i) in the subparagraph heading, by striking ''CHILD'' and inserting ''SPOUSAL''; and

(ii) by striking ''child or''.

(e) CONFORMING AMENDMENT RELATING TO MAINTENANCE OF EFFORT FOR CHILDREN.—Section 1902(gg)(4) of the Social Security Act (42 U.S.C. 1396a(gg)(4)) is amended by adding at the end the following:

''(C) STATES THAT EXPAND ADULT COVERAGE AND ELECT TO OPT-OUT OF TRANSITIONAL COVERAGE.—

''(i) IN GENERAL.—For purposes of determining compliance with the requirements of paragraph (2), a State which exercises the option under sections 1925(a)(6) and 1931(c)(3) to provide no transitional medical assistance or other extended eligibility (as applicable) shall not, as a result of exercising such option, be considered to have in effect eligibility standards, methodologies, or procedures

described in clause (ii) that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act.

''(ii) STANDARDS, METHODOLOGIES, OR PROCEDURES DESCRIBED.—The eligibility standards, methodologies, or procedures described in this clause are those standards, methodologies, or procedures applicable to determining the eligibility for medical assistance of any child under 19 years of age (or such higher age as the State may have elected).''.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect on April 1, 2014.

**SEC. 213. EXPRESS LANE ELIGIBILITY.**

Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking ''September 30, 2014'' and inserting ''September 30, 2015''.

**SEC. 214. PEDIATRIC QUALITY MEASURES.**

(a) CONTINUATION OF FUNDING FOR PEDIATRIC QUALITY MEASURES FOR IMPROVING THE QUALITY OF CHILDREN'S HEALTH CARE.—Section 1139B(e) of the

Social Security Act (42 U.S.C. 1320b–9b(e)) is amended by adding at the end the following: ''Of the funds appropriated under this subsection, not less than $15,000,000 shall be used to carry out section 1139A(b).''.

(b) ELIMINATION OF RESTRICTION ON MEDICAID QUALITY MEASUREMENT PROGRAM.—Section 1139B(b)(5)(A) of the Social Security Act (42 U.S.C. 1320b–9b(b)(5)(A)) is amended by striking ''The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)''.

**SEC. 215. SPECIAL DIABETES PROGRAMS.**

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2014'' and inserting ''2019''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2014'' and inserting ''2019''.

# Subtitle C—Human Services Extensions

**SEC. 221. ABSTINENCE EDUCATION GRANTS.**

(a) IN GENERAL.—Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''2010 through 2014'' and inserting ''2015 through 2019''; and

(2) in subsection (d)—

(A) by striking ''2010 through 2014'' and inserting ''2015 through 2019''; and

(B) by striking the second sentence.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2014.

**SEC. 222. PERSONAL RESPONSIBILITY EDUCATION PROGRAM.**

(a) IN GENERAL.—Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(1) in subsection (a)—

(A) in paragraph (1)(A), by striking ''2010 through 2014'' and inserting ''2015 through 2019'';

(B) in paragraph (4)—

(i) in subparagraph (A)—

(I) by striking ''2010 or 2011'' and inserting ''2015 or 2016'';

(II) by striking ''2010 through 2014'' and inserting ''2015 through 2019''; and

(III) by striking ''2012 through 2014'' and inserting ''2017 through 2019''; and

(ii) in subparagraph (B)(i)—

(I) by striking ''2012, 2013, and 2014'' and inserting ''2017, 2018, and 2019''; and

(II) by striking ''2010 or 2011'' and inserting ''2015 or 2016''; and

(C) in paragraph (5), by striking ''2009'' and inserting ''2014'';

(2) in subsection (b)(2)(A), in the matter preceding clause (i), by inserting ''and youth at risk of becoming victims of sex trafficking (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7102(10))) or victims of a severe form of trafficking in persons described in paragraph (9)(A) of that Act (22 U.S.C. 7102(9)(A)'' after ''adolescents'';

(3) in subsection(c)(1), by inserting ''youth at risk of becoming victims of sex trafficking (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7102(10))) or victims of a severe form of trafficking in persons described in paragraph (9)(A) of that Act (22 U.S.C. 7102(9)(A),'' after ''youth in foster care,''; and

(4) in subsection (f), by striking ''2010 through 2014'' and inserting ''2015 through 2019''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2014.

**SEC. 223. FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.**

(a) IN GENERAL.—Section 501(c) of the Social Security Act (42 U.S.C. 701(c)) is amended—

(1) in paragraph (1)(A), by striking clause (iv) and inserting the following:

''(iv) $6,000,000 for each of fiscal years 2014 through 2018.''; and

(2) by striking paragraph (5).

(b) PREVENTION OF DUPLICATE APPROPRIATIONS FOR FISCAL YEAR 2014.—Expenditures made for fiscal year 2014 pursuant to section 501(c)(iv) of the Social Security Act (42 U.S.C. 701(c)(iv)), as amended by section 1203 of division B of the Bipartisan Budget Act of 2013

(Public Law 113–67), shall be charged to the appropriation for that fiscal year provided by the amendments made by this section.

**SEC. 224. HEALTH WORKFORCE DEMONSTRATION PROJECT FOR LOW-INCOME INDIVIDUALS.**

Section 2008(c)(1) of the Social Security Act (42 U.S.C. 1397g(c)(1)) is amended by striking '' through 2014'' and inserting ''2012, and only to carry out subsection (a), $85,000,000 for each of fiscal years 2013 through 2016''.

# TITLE III—MEDICARE AND MEDICAID PROGRAM INTEGRITY

**SEC. 301. REDUCING IMPROPER MEDICARE PAYMENTS.**

(a) MEDICARE ADMINISTRATIVE CONTRACTOR IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—

(1) IN GENERAL.—Section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) is amended—

(A) in subsection (a)(4)—

(i) by redesignating subparagraph (G) as subparagraph (H); and

(ii) by inserting after subparagraph (F) the following new subparagraph:

''(G) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—Having in place an im-

proper payment outreach and education program described in subsection (h).''; and

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

''(h) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—

''(1) IN GENERAL.—In order to reduce improper payments under this title, each medicare administrative contractor shall establish and have in place an improper payment outreach and education program under which the contractor, through outreach, education, training, and technical assistance activities, shall provide providers of services and suppliers located in the region covered by the contract under this section with the information described in paragraph (3). The activities described in the preceding sentence shall be conducted on a regular basis.

''(2) FORMS OF OUTREACH, EDUCATION, TRAINING, AND TECHNICAL ASSISTANCE ACTIVITIES.—The outreach, education, training, and technical assistance activities under a payment outreach and education program shall be carried out through any of the following:

"(A) Emails and other electronic communications.

"(B) Webinars.

"(C) Telephone calls.

"(D) In-person training.

"(E) Other forms of communications determined appropriate by the Secretary.

"(3) INFORMATION TO BE PROVIDED THROUGH ACTIVITIES.—The information to be provided to providers of services and suppliers under a payment outreach and education program shall include all of the following information:

"(A) A list of the provider's or supplier's most frequent and expensive payment errors over the last quarter.

"(B) Specific instructions regarding how to correct or avoid such errors in the future.

"(C) A notice of all new topics that have been approved by the Secretary for audits conducted by recovery audit contractors under section 1893(h).

"(D) Specific instructions to prevent future issues related to such new audits.

"(E) Other information determined appropriate by the Secretary.

''(4) ERROR RATE REDUCTION TRAINING.—

''(A) IN GENERAL.—The activities under a payment outreach and education program shall include error rate reduction training.

''(B) REQUIREMENTS.—

''(i) IN GENERAL.—The training described in subparagraph (A) shall—

''(I) be provided at least annually; and

''(II) focus on reducing the improper payments described in paragraph (5).

''(C) INVITATION.—A medicare administrative contractor shall ensure that all providers of services and suppliers located in the region covered by the contract under this section are invited to attend the training described in subparagraph (A) either in person or online.

''(5) PRIORITY.—A medicare administrative contractor shall give priority to activities under the improper payment outreach and education program that will reduce improper payments for items and services that—

''(A) have the highest rate of improper payment;

"(B) have the greatest total dollar amount of improper payments;

"(C) are due to clear misapplication or misinterpretation of Medicare policies;

"(D) are clearly due to common and inadvertent clerical or administrative errors; or

"(E) are due to other types of errors that the Secretary determines could be prevented through activities under the program.

"(6) INFORMATION ON IMPROPER PAYMENTS FROM RECOVERY AUDIT CONTRACTORS.—

"(A) IN GENERAL.—In order to assist medicare administrative contractors in carrying out improper payment outreach and education programs, the Secretary shall provide each contractor with a complete list of improper payments identified by recovery audit contractors under section 1893(h) with respect to providers of services and suppliers located in the region covered by the contract under this section. Such information shall be provided on a quarterly basis.

"(B) INFORMATION.—The information described in subparagraph (A) shall include the following information:

''(i) The providers of services and suppliers that have the highest rate of improper payments.

''(ii) The providers of services and suppliers that have the greatest total dollar amounts of improper payments.

''(iii) The items and services furnished in the region that have the highest rates of improper payments.

''(iv) The items and services furnished in the region that are responsible for the greatest total dollar amount of improper payments.

''(v) Other information the Secretary determines would assist the contractor in carrying out the improper payment outreach and education program.

''(C) FORMAT OF INFORMATION.—The information furnished to medicare administrative contractors by the Secretary under this paragraph shall be transmitted in a manner that permits the contractor to easily identify the areas of the Medicare program in which targeted outreach, education, training, and technical assistance would be most effective. In car-

rying out the preceding sentence, the Secretary shall ensure that—

"(i) the information with respect to improper payments made to a provider of services or supplier clearly displays the name and address of the provider or supplier, the amount of the improper payment, and any other information the Secretary determines appropriate; and

"(ii) the information is in an electronic, easily searchable database.

"(7) COMMUNICATIONS.—All communications with providers of services and suppliers under a payment outreach and education program are subject to the standards and requirements of subsection (g).

"(8) FUNDING.—After application of paragraph (1)(C) of section 1893(h), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors under such section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of carrying out this subsection and to implement corrective actions to help reduce the error rate of payments under this title. The amount retained under the preceding sentence shall not exceed an

amount equal to 25 percent of the amounts recovered under section 1893(h).''.

(2) FUNDING CONFORMING AMENDMENT.—Section 1893(h)(2) of the Social Security Act (42 U.S.C. 1395ddd(h)(2)) is amended by inserting ''or section 1874(h)(8)'' after ''paragraph (1)(C)''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2015.

(b) TRANSPARENCY.—Section 1893(h)(8) of the Social Security Act (42 U.S.C. 1395ddd(h)(8)) is amended—

(1) by striking ''REPORT.—The Secretary'' and inserting ''REPORT.—

''(A) IN GENERAL.—The Secretary''; and

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

''(B) INCLUSION OF CERTAIN INFORMATION.—

''(i) IN GENERAL.—For reports submitted under this paragraph for 2015 or a subsequent year, each such report shall include the information described in clause (ii) with respect to each of the following categories of audits carried out by recovery audit contractors under this subsection:

''(I) Automated.

"(II) Complex.

"(III) Medical necessity review.

"(IV) Part A.

"(V) Part B.

"(VI) Durable medical equipment.

"(ii) INFORMATION DESCRIBED.—For purposes of clause (i), the information described in this clause, with respect to a category of audit described in clause (i), is the result of all appeals for each individual level of appeals in such category.".

(c) RECOVERY AUDIT CONTRACTOR DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary shall conduct a demonstration project under title XVIII of the Social Security Act that—

(A) targets audits by recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) with respect to high error providers of services and suppliers identified under paragraph (3); and

(B) rewards low error providers of services and suppliers identified under such paragraph.

(2) SCOPE.—

(A) DURATION.—The demonstration project shall be implemented not later than January 1, 2015, and shall be conducted for a period of three years.

(B) DEMONSTRATION AREA.—In determining the geographic area of the demonstration project, the Secretary shall consider the following:

(i) The total number of providers of services and suppliers in the region.

(ii) The diversity of types of providers of services and suppliers in the region.

(iii) The level and variation of improper payment rates of and among individual providers of services and suppliers in the region.

(iv) The inclusion of a mix of both urban and rural areas.

(3) IDENTIFICATION OF LOW ERROR AND HIGH ERROR PROVIDERS OF SERVICES AND SUPPLIERS.—

(A) IN GENERAL.—In conducting the demonstration project, the Secretary shall identify the following two groups of providers in accordance with this paragraph:

(i) Low error providers of services and suppliers.

(ii) High error providers of services and suppliers.

(B) ANALYSIS.—For purposes of identifying the groups under subparagraph (A), the Secretary shall analyze the following as they relate to the total number and amount of claims submitted in the area and by each provider:

(i) The improper payment rates of individual providers of services and suppliers.

(ii) The amount of improper payments made to individual providers of services and suppliers.

(iii) The frequency of errors made by the provider of services or supplier over time.

(iv) Other information determined appropriate by the Secretary.

(C) ASSIGNMENT BASED ON COMPOSITE SCORE.—The Secretary shall assign selected providers of services and suppliers under the demonstration program based on a composite score determined using the analysis under subparagraph (B) as follows:

(i) Providers of services and suppliers with high, expensive, and frequent errors shall receive a high score and be identified as high error providers of services and suppliers under subparagraph (A).

(ii) Providers of services and suppliers with few, inexpensive, and infrequent errors shall receive a low score and be identified as low error providers of services and suppliers under such subparagraph.

(iii) Only a small proportion of the total providers of services and suppliers and individual types of providers of services and suppliers in the geographic area of the demonstration project shall be assigned to either group identified under such subparagraph.

(D) TIMEFRAME OF IDENTIFICATION.—

(i) IN GENERAL.—Any identification of a provider of services or a supplier under subparagraph (A) shall be for a period of 12 months.

(ii) REEVALUATION.—The Secretary shall reevaluate each such identification at the end of such period.

(iii) USE OF MOST CURRENT INFORMATION.—In carrying out the reevaluation under clause (ii) with respect to a provider of services or supplier, the Secretary shall—

(I) consider the most current information available with respect to the provider of services or supplier under the analysis under subparagraph (B); and

(II) take into account improvement or regression of the provider of services or supplier.

(4) ADJUSTMENT OF RECORD REQUEST MAXIMUM.—Under the demonstration project, the Secretary shall establish procedures to—

(A) increase the maximum record request made by recovery audit contractors to providers of services and suppliers identified as high error providers of services and suppliers under paragraph (3); and

(B) decrease the maximum record request made by recovery audit contractors to providers of services and suppliers identified as low error

providers of services and supplier under such paragraph.

(5) ADDITIONAL ADJUSTMENTS.—

(A) IN GENERAL.—Under the demonstration project, the Secretary may make additional adjustments to requirements for recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) and the conduct of audits with respect to low error providers of services and suppliers identified under paragraph (3) and high error providers of services and suppliers identified under such paragraph as the Secretary determines necessary in order to incentivize reductions in improper payment rates under title XVIII of such Act (42 U.S.C. 1395 et seq.).

(B) LIMITATION.—The Secretary shall not exempt any group of providers of services or suppliers in the demonstration project from being subject to audit by a recovery audit contractor under such section 1893(h).

(6) EVALUATION AND REPORT.—

(A) EVALUATION.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the dem-

onstration project under this subsection. The evaluation shall include an analysis of—

(i) the error rates of providers of services and suppliers—

(I) identified under paragraph (3) as low error providers of services and suppliers;

(II) identified under such paragraph as high error providers of services and suppliers; and

(III) that are located in the geographic area of the demonstration project and are not identified as either a low error or high error provider of services or supplier under such paragraph; and

(ii) any improvements in the error rates of those high error providers of services and suppliers identified under such paragraph.

(B) REPORT.—Not later than 12 months after completion of the demonstration project, the Inspector General shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together

with recommendations on whether the demonstration project should be continued or expanded, including on a permanent or nationwide basis.

(7) FUNDING.—

(A) FUNDING FOR IMPLEMENTATION.—For purposes of carrying out the demonstration project under this subsection (other than the evaluation and report under paragraph (6)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $10,000,000 to the Centers for Medicare & Medicaid Services Program Management Account.

(B) FUNDING FOR INSPECTOR GENERAL EVALUATION AND REPORT.—For purposes of carrying out the evaluation and report under paragraph (6), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under such section 1817 and the Federal Supplementary Medical Insurance

Trust Fund under such section 1841, in such proportion as the Secretary determines appropriate, of $245,000 to the Inspector General of the Department of Health and Human Services.

(C) AVAILABILITY.—Amounts transferred under subparagraph (A) or (B) shall remain available until expended.

(8) DEFINITIONS.—In this section:

(A) DEMONSTRATION PROJECT.—The term ''demonstration project'' means the demonstration project under this subsection.

(B) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given that term in section 1861(u).

(C) RECOVERY AUDIT CONTRACTOR.—The term ''recovery audit contractor'' means an entity with a contract under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)).

(D) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(E) SUPPLIER.—The term ''supplier'' has the meaning given that term in section 1861(d).

**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.**

(a) IN GENERAL.—Section 1903(q)(4)(A) of the Social Security Act (42 U.S.C. 1396b(q)(4)(A)) is amended to read as follows:

''(4)(A) The entity's function includes a statewide program for the—

''(i) investigation and prosecution, or referral for prosecution or other action, of complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title or under a waiver of such plan;

''(ii) at the option of the entity, investigation and prosecution, or referral for prosecution or other action, of complaints of abuse or neglect of individuals in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance in a home or community based setting that is paid for under the State plan under this title or under a waiver of such plan; and

''(iii) at the option of the entity, investigation and prosecution, or referral for prosecution or other action, of complaints of abuse or neglect of patients residing in board and care facilities.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2015.

**SEC. 303. IMPROVED USE OF FUNDS RECEIVED BY THE HHS INSPECTOR GENERAL FROM OVERSIGHT AND INVESTIGATIVE ACTIVITIES.**

(a) IN GENERAL.—Section 1128C(b) of the Social Security Act (42 U.S.C. 1320a–7c(b)) is amended to read as follows:

''(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

''(1) COLLECTIONS FROM MEDICARE AND MEDICAID RECOVERY ACTIONS.—Notwithstanding section 3302 of title 31, United States Code, or any other provision of law affecting the crediting of collections, the Inspector General of the Department of Health and Human Services may receive and retain for current use three percent of all amounts collected pursuant to civil debt collection and administrative enforcement actions related to false claims or frauds

involving the Medicare program under title XVIII or the Medicaid program under title XIX.

''(2) CREDITING.—Funds received by the Inspector General under paragraph (1) shall be deposited as offsetting collections to the credit of any appropriation available for oversight and enforcement activities of the Inspector General permitted under subsection (a), and shall remain available until expended.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to funds received from settlements finalized, judgments entered, or final agency decisions issued, on or after the date of the enactment of this Act.

**SEC. 304. PREVENTING AND REDUCING IMPROPER MEDICARE AND MEDICAID EXPENDITURES.**

(a) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(4) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

''(A) IN GENERAL.—For plan year 2015 and subsequent plan years, subject to subpara-

graph (B), the Secretary shall prohibit PDP sponsors of prescription drug plans from paying claims for prescription drugs under this part that do not include a valid prescriber National Provider Identifier.

''(B) PROCEDURES.—The Secretary shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).

''(C) REPORT.—Not later than January 1, 2017, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B).''.

(b) REFORMING HOW CMS TRACKS AND CORRECTS THE VULNERABILITIES IDENTIFIED BY RECOVERY AUDIT CONTRACTORS.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (8), as amended by section 301, by adding at the end the following new subparagraphs:

''(C) INCLUSION OF IMPROPER PAYMENT VULNERABILITIES IDENTIFIED.—For reports submitted under this paragraph for 2015 or a

subsequent year, each such report shall include—

''(i) a description of—

''(I) the types and financial cost to the program under this title of improper payment vulnerabilities identified by recovery audit contractors under this subsection; and

''(II) how the Secretary is addressing such improper payment vulnerabilities; and

''(ii) an assessment of the effectiveness of changes made to payment policies and procedures under this title in order to address the vulnerabilities so identified.

''(D) LIMITATION.—The Secretary shall ensure that each report submitted under subparagraph (A) does not include information that the Secretary determines would be sensitive or would otherwise negatively impact program integrity.''; and

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

''(10) ADDRESSING IMPROPER PAYMENT VULNERABILITIES.—The Secretary shall address im-

proper payment vulnerabilities identified by recovery audit contractors under this subsection in a timely manner, prioritized based on the risk to the program under this title.''.

(c) STRENGTHENING MEDICAID PROGRAM INTEGRITY THROUGH FLEXIBILITY.—Section 1936 of the Social Security Act (42 U.S.C. 1396u–6) is amended—

(1) in subsection (a), by inserting '', or otherwise,'' after ''entities''; and

(2) in subsection (e)—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''(including the costs of equipment, salaries and benefits, and travel and training)'' after ''Program under this section''; and

(B) in paragraph (3), by striking ''by 100'' and inserting ''by 100, or such number as determined necessary by the Secretary to carry out the Program under this section,''.

(d) ACCESS TO THE NATIONAL DIRECTORY OF NEW HIRES.—Section 453(j) of the Social Security Act (42 U.S.C. 653(j)) is amended by adding at the end the following new paragraph:

''(12) INFORMATION COMPARISONS AND DISCLOSURES TO ASSIST IN ADMINISTRATION OF THE

MEDICARE PROGRAM AND STATE HEALTH SUBSIDY PROGRAMS.—

"(A) DISCLOSURE TO THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—The Administrator of the Centers for Medicare & Medicaid shall have access to the information in the National Directory of New Hires for purposes of determining the eligibility of an applicant for, or enrollee in, the Medicare program under title XVIII or an applicable State health subsidy program (as defined in section 1413(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18083(e)).

"(B) DISCLOSURE TO THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

"(i) IN GENERAL.—If the Inspector General of the Department of Health and Human Services transmits to the Secretary the names and social security account numbers of individuals, the Secretary shall disclose to the Inspector General information on such individuals and their employ-

ers maintained in the National Directory of New Hires.

''(ii) USE OF INFORMATION.—The Inspector General of the Department of Health and Human Services may use information provided under clause (i) only for purposes of —

''(I) enforcing mandatory and permissive exclusions under title XI; or

''(II) evaluating the integrity of the Medicare program or an applicable State health subsidy program (as defined in section 1413(e) of the Patient Protection and Affordable Care Act).

The authority under this clause is in addition to any authority conferred under the Inspector General Act of 1978 (5 U.S.C. App).

''(C) DISCLOSURE TO STATE AGENCIES.—

''(i) IN GENERAL.—If, for purposes of determining the eligibility of an applicant for, or an enrollee in, an applicable State health subsidy program (as defined in sec-

tion 1413(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18083(e)), a State agency responsible for administering such program transmits to the Secretary the names, dates of birth, and social security account numbers of individuals, the Secretary shall disclose to such State agency information on such individuals and their employers maintained in the National Directory of New Hires, subject to this subparagraph.

''(ii) CONDITION ON DISCLOSURE BY THE SECRETARY.—The Secretary shall make a disclosure under clause (i) only to the extent that the Secretary determines that the disclosure would not interfere with the effective operation of the program under this part.

''(iii) USE AND DISCLOSURE OF INFORMATION BY STATE AGENCIES.—

''(I) IN GENERAL.—A State agency may not use or disclose information provided under clause (i) except for purposes of determining the eligibility of an applicant for, or an

enrollee in, a program referred to in clause (i).

''(II) INFORMATION SECURITY.—The State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of information obtained under clause (i) and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures.

''(III) PENALTY FOR MISUSE OF INFORMATION.—An officer or employee of the State agency who fails to comply with this clause shall be subject to the sanctions under subsection (l)(2) to the same extent as if such officer or employee were an officer or employee of the United States.

''(iv) PROCEDURAL REQUIREMENTS.—State agencies requesting information under clause (i) shall adhere to uniform procedures established by the Secretary

governing information requests and data matching under this paragraph.

''(v) REIMBURSEMENT OF COSTS.—The State agency shall reimburse the Secretary, in accordance with subsection (k)(3), for the costs incurred by the Secretary in furnishing the information requested under this subparagraph.''.

(e) IMPROVING THE SHARING OF DATA BETWEEN THE FEDERAL GOVERNMENT AND STATE MEDICAID PROGRAMS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a plan to encourage and facilitate the participation of States in the Medicare-Medicaid Data Match Program (commonly referred to as the ''Medi-Medi Program'') under section 1893(g) of the Social Security Act (42 U.S.C. 1395ddd(g)).

(2) PROGRAM REVISIONS TO IMPROVE MEDI-MEDI DATA MATCH PROGRAM PARTICIPATION BY STATES.—Section 1893(g)(1)(A) of the Social Security Act (42 U.S.C. 1395ddd(g)(1)(A)) is amended—

(A) in the matter preceding clause (i), by inserting ''or otherwise'' after ''eligible entities'';

(B) in clause (i)—

(i) by inserting ''to review claims data'' after ''algorithms''; and

(ii) by striking ''service, time, or patient'' and inserting ''provider, service, time, or patient'';

(C) in clause (ii)—

(i) by inserting ''to investigate and recover amounts with respect to suspect claims'' after ''appropriate actions''; and

(ii) by striking ''; and'' and inserting a semicolon;

(D) in clause (iii), by striking the period and inserting ''; and''; and

(E) by adding at end the following new clause:

''(iv) furthering the Secretary's design, development, installation, or enhancement of an automated data system architecture—

''(I) to collect, integrate, and assess data for purposes of program in-

tegrity, program oversight, and administration, including the Medi-Medi Program; and

''(II) that improves the coordination of requests for data from States.''.

(3) PROVIDING STATES WITH DATA ON IMPROPER PAYMENTS MADE FOR ITEMS OR SERVICES PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Secretary shall develop and implement a plan that allows each State agency responsible for administering a State plan for medical assistance under title XIX of the Social Security Act access to relevant data on improper or fraudulent payments made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for health care items or services provided to dual eligible individuals.

(B) DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this paragraph, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits

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

# TITLE IV—OTHER PROVISIONS

## SEC. 401. COMMISSION ON IMPROVING PATIENT DIRECTED HEALTH CARE.

(a) FINDINGS.—Congress finds the following:

(1) In order to elevate the role of patient choices in the health care system, the American public must engage in an informed, national, public debate on how the current health care system empowers and informs health care decision-making, and what can be done to improve the likelihood patients receive the care they want and need.

(2) Research suggests that patients often do not receive the care they want. As a result, the end of life is associated with a substantial burden of suffering by the patient and negative health and financial consequences that extend to family members and society.

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

The health care system should embed principles that take into account patient wishes.

(4) Decisions concerning health care, including end-of-life issues, affect an increasing number of Americans.

(5) Medical advances are prolonging life expectancy in the United States both in acute life-threatening situations and protracted battles with illness. These advances raise new challenges surrounding health care decision-making.

(6) The United States health care system should promote consideration of a person's preference in health care decision-making and end-of-life choices.

(b) COMMISSION.—The Social Security Act is amended by inserting after section 1150B (42 U.S.C. 1320b–24) the following new section:

**"SEC. 1150C. COMMISSION ON IMPROVING PATIENT DIRECTED HEALTH CARE.**

''(a) PURPOSES.—The purposes of this section are to—

''(1) provide a forum for a nationwide public debate on improving patient self-determination in health care decision-making;

''(2) identify strategies that ensure every American has the health care they want; and

''(3) provide recommendations to Congress that result from the debate.

''(b) ESTABLISHMENT.—The Secretary shall establish an entity to be known as the Commission on Improving Patient Directed Health Care (referred to in this section as the 'Commission').

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members. One member shall be the Secretary. The Comptroller General of the United States shall appoint 14 members.

''(2) QUALIFICATIONS.—The membership of the Commission shall include—

''(A) health care consumers impacted by decision-making in advance of a health care crisis, such as individuals of advanced age, individuals with chronic, terminal and mental illnesses, family care givers, and individuals with disabilities;

''(B) providers in settings where crucial health care decision-making occurs, such as those working in intensive care settings, emer-

gency room departments, primary care settings, nursing homes, hospice, or palliative care settings;

"(C) payors ensuring patients get the level of care they want;

"(D) experts in advance care planning, hospice, palliative care, information technology, bioethics, aging policy, disability policy, pediatric ethics, cultural sensitivity, psychology, and health care financing;

"(E) individuals who represent culturally diverse perspectives on patient self-determination and end-of-life issues; and

"(F) members of the faith community.

"(d) PERIOD OF APPOINTMENT.—Members of the Commission shall be appointed for the life of the Commission. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment.

"(e) DESIGNATION OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Commission have been appointed, the Comptroller General shall designate the chairperson of the Commission.

''(f) SUBCOMMITTEES.—The Commission may establish subcommittees if doing so increases the efficiency of the Commission in completing tasks.

''(g) DUTIES.—

''(1) HEARINGS.—Not later than 90 days after the date of designation of the chairperson under subsection (e), the Commission shall hold no fewer than 8 hearings to examine—

''(A) the current state of health care decision-making and advance care planning laws in the United States at the Federal level and across the States, as well as options for improving advance care planning tools, especially with regard to use, portability, and storage;

''(B) consumer-focused approaches that educate the American public about patient choices, care planning, and other end-of-life issues;

''(C) the use of comprehensive, patient-centered care plans by providers, the impact care plans have on health care delivery and spending, and methods to expand the use of high quality care planning tools in both public and private health care systems;

"(D) the role of electronic medical records and other technologies in improving patient-directed health care;

"(E) innovative tools for improving patient experience with advanced illness, such as palliative care, hospice, and other models;

"(F) the role social determinants of health, such as socio-economic status, play in patient self-direction in health care;

"(G) the use of culturally-competent tools for health care decision-making;

"(H) strategies for educating providers and increasing provider engagement on care planning, palliative care, hospice care, and other issues surrounding honoring patient choices;

"(I) the sociological and psychological factors that influence health care decision-making and end-of-life choices; and

"(J) the role of spirituality and religion in patient self-determination in health care.

"(2) ADDITIONAL HEARINGS.—The Commission may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined necessary by the Commission in

carrying out the purposes of this section. Such additional hearings do not have to be completed within the time period specified but shall not delay the other activities of the Commission under this section.

''(3) NUMBER AND LOCATION OF HEARINGS AND ADDITIONAL HEARINGS.—The Commission shall hold no fewer than 8 hearings as indicated in paragraph (1) and in sufficient number in order to receive information that reflects—

''(A) the geographic differences throughout the United States;

''(B) diverse populations; and

''(C) a balance among urban and rural populations.

''(4) INTERACTIVE TECHNOLOGY.—The Commission may encourage public participation in hearings through interactive technology and other means as determined appropriate by the Commission.

''(5) REPORT TO THE AMERICAN PEOPLE ON PATIENT DIRECTED HEALTH CARE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Commission shall prepare and make available to health care consumers through the Internet and other appropriate public

channels, a report to be entitled, 'Report to the American People on Patient Directed Health Care'. Such a report shall be understandable to the general public and include—

"(A) a summary of—

"(i) the hearings described in such paragraphs;

"(ii) how the current health care system empowers and informs decision-making in advance of a health care crisis;

"(iii) factors that contribute to the provision of health care that does not adhere to patient wishes;

"(iv) the impact of care that does not follow patient choices, particularly at the end-of-life, on patients, families, providers, spending, and the health care system;

"(v) the laws surrounding advance care planning and health care decision-making including issues of portability, use, and storage;

"(vi) consumer-focused approaches to education of the American public about patient choices, care planning, and other end-of-life issues;

''(vii) the role of care plans in health care decision-making;

''(viii) the role of providers in ensuring patients receive the care they want;

''(ix) the role of electronic medical records and other technologies in improving patient directed health care;

''(x) the impact of social determinants on patient self-direction in health care services;

''(xi) the use of culturally competent methods for health care decision-making;

''(xii) the sociological and psychological factors that influence patient self-determination; and

''(xiii) the role of spirituality and religion in health care decision-making and end-of-life care;

''(B) best practices from communities, providers, and payors that document patient wishes and provide health care that adheres to those wishes; and

''(C) information on educating providers about health care decision-making and end-of-life issues.

''(6) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the hearings, the Commission shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on patient self-determination in health care and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

''(h) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (g)(6), the Commission shall submit to Congress and the President a final set of recommendations. The recommendations must be comprehensive and detailed. The recommendations must contain recommendations or proposals for legislative or administrative action as the Commission deems appropriate, including proposed legislative language to carry out the recommendations or proposals.

''(i) ADMINISTRATION.—

''(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Commission who shall be

appointed by the chairperson of the Commission in consultation with the members of the Commission.

''(2) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the Senate.

''(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this section. Upon request of the Commission the head of such department or agency shall furnish such information.

''(4) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and

under the same conditions as other departments and agencies of the Federal Government.

''(j) DETAIL.—Not more than 4 Federal Government employees employed by the Department of Labor, 4 Federal Government employees employed by the Social Security Administration, and 8 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Commission under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

''(k) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''(l) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Commission, the Commission shall report to Congress and make public a detailed description of the expenditures of the Commission used to carry out its duties under this section.

''(m) SUNSET OF COMMISSION.—The Commission shall terminate on the date that is 3 years after the date on which all the members of the Commission have been appointed under subsection (c)(1) and appropriations are first made available to carry out this section.

''(n) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Commission under subsection (h), the President shall submit a report to Congress which shall contain—

''(1) additional views and comments on such recommendations; and

''(2) recommendations for such legislation and administrative action as the President considers appropriate.

''(o) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this section, $3,000,000 for each of fiscal years 2014 and 2015.

''(2) REPORT TO THE AMERICAN PEOPLE ON PATIENT DIRECTED HEALTH CARE.—There are authorized to be appropriated for the preparation and dissemination of the Report to the American People on Patient Directed Health Care described in sub-

section (g)(5), $1,000,000 for the fiscal year in which the report is required to be submitted.''.

**SEC. 402. EXPANSION OF THE DEFINITION OF INPATIENT HOSPITAL SERVICES FOR CERTAIN CANCER HOSPITALS.**

Section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b)) is amended—

(1) in paragraph (3)—

(A) by inserting ''(A)'' after ''(3)'';

(B) by adding ''and'' after the semicolon at the end; and

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

''(B) subject to the third sentence of this subsection, with respect to a hospital that—

''(i) is described in section 1886(d)(1)(B)(v); and

''(ii) as of the date of the enactment of the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014, is located in the same building, or on the same campus, as another hospital (as described in sections 412.22(e) and 412.22(f) of title 42, Code of Federal Regulations, as in effect on such date of enactment );

items and services described in paragraphs (1) and (2) furnished on or after October 1, 2014, by such hospital described in section 1886(d)(1)(B)(v) or by others under arrangements with them made by the hospital;''; and

(2) by adding at the end the following new flush sentence:

''Paragraph (3)(B) shall only apply to payments with respect to the total number of the hospital's patient days at any satellite of the hospital or such days at another hospital providing services under arrangements to the hospital, determined as of the date of the enactment of the Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014.''.

**SEC. 403. QUALITY MEASURES FOR CERTAIN POST-ACUTE CARE PROVIDERS RELATING TO NOTICE AND TRANSFER OF PATIENT HEALTH INFORMATION AND PATIENT CARE PREFERENCES.**

(a) DEVELOPMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide for the development of one or more quality measures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to accurately communicate the existence and provide for the transfer of patient health information and patient care preferences when an indi-

vidual transitions from a hospital to return home or move to other post-acute care settings.

(b) USE OF MEASURE DEVELOPERS.—The Secretary shall arrange for the development of such measures by appropriate measure developers.

(c) ENDORSEMENT.—The Secretary shall arrange for such developed measures to be submitted for endorsement to a consensus-based entity as described in section 1890(a) of the Social Security Act (42 U.S.C. 1395aaa(a)).

(d) USE OF MEASURES.—The Secretary shall, through notice and comment rulemaking, use such measures under the quality reporting programs with respect to—

(1) inpatient hospitals under section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii));

(2) skilled nursing facilities under section 1888(e) of such Act (42 U.S.C. 1395yy(e));

(3) home health services under section 1895(b)(3)(B)(v) of such Act (42 U.S.C. 1395fff(b)(3)(B)(v)); and

(4) other providers of services (as defined in section 1861(u) of such Act) and suppliers (as de-

fined in section 1861(d) of such Act) that the Secretary determines appropriate.

**SEC. 404. CRITERIA FOR MEDICALLY NECESSARY, SHORT INPATIENT HOSPITAL STAYS.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall consult with, and seek input from, interested stakeholders to determine appropriate criteria for payment under the Medicare program under title XVIII of the Social Security Act of an inpatient hospital admission that—

(1) is medically necessary; and

(2) is an inpatient hospital stay that is less than two midnights, as described in section 412.3 of title 42, Code of Federal Regulation, as finalized in the final rule published by the Centers for Medicare & Medicaid Services in the Federal Register on August 19, 2013 (78 Federal Register 50496) entitled ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status''.

(b) INTERESTED STAKEHOLDERS.—In subsection (a), the term ''interested stakeholders'' means the following:

(1) Hospitals.

(2) Physicians

(3) Medicare administrative contractors under section 1874A of the Social Security Act (42 U.S.C. 1395kk–1).

(4) Recovery audit contractors under section 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

(5) Other parties determined appropriate by the Secretary.

**SEC. 405. TRANSPARENCY OF REASONS FOR EXCLUDING ADDITIONAL PROCEDURES FROM THE MEDICARE AMBULATORY SURGICAL CENTER (ASC) APPROVED LIST.**

Section 1833(i)(1) of the Social Security Act (42 U.S.C. 1395l(i)(1)) is amended by adding at the end the following: ''In updating such lists for application in years beginning after December 31, 2014, for each procedure that was not proposed but was requested to be included on such lists during the public comment where the Secretary does not finalize (in the final rule updating such lists) to so include, the Secretary shall describe in such

final rule the specific safety criteria for not including such requested procedure on such lists.''.

**SEC. 406. SUPERVISION IN CRITICAL ACCESS HOSPITALS.**

(a) GENERAL SUPERVISION IN CRITICAL ACCESS HOSPITALS.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended by adding at the end the following new paragraph:

''(6) SUPERVISION.—In the case of services furnished on or after the date of the enactment of this paragraph, the minimum level of supervision with respect to outpatient therapeutic critical access hospital services shall be general supervision (as defined by the Secretary).''.

(b) SUPERVISION OF CARDIAC AND PULMONARY REHABILITATION PROGRAMS IN CRITICAL ACCESS HOSPITALS.—Section 1861(eee)(2)(B) of the Social Security Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting '', or in the case of a critical access hospital, a physician, or (beginning on the date of enactment of Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014) a nurse practitioner, clinical nurse specialist, or physician assistant (as such terms are defined in subsection (aa)(5)),'' after ''a physician''.

**SEC. 407. REQUIRING STATE LICENSURE OF BIDDING ENTITIES UNDER THE COMPETITIVE ACQUISITION PROGRAM FOR CERTAIN DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS).**

Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended by adding at the end the following new subparagraph:

''(G) REQUIRING STATE LICENSURE OF BIDDING ENTITIES.—With respect to rounds of competitions beginning on or after the date of enactment of this subparagraph, the Secretary may only accept a bid from an entity for an area if the entity meets applicable State licensure requirements for such area for all items in such bid for a product category.''.

**SEC. 408. RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.**

(a) RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.—

(1) IN GENERAL.—Section 1861(dd)(3)(B) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(B)) is amended—

(A) by striking ''or nurse'' and inserting '', the nurse''; and

(B) by inserting '', or the physician assistant (as defined in such subsection)'' after ''subsection (aa)(5))''.

(2) CLARIFICATION OF HOSPICE ROLE OF PHYSICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting ''or a physician assistant'' after ''a nurse practitioner''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2015.

**SEC. 409. REMOTE PATIENT MONITORING PILOT PROJECTS.**

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Secretary shall conduct pilot projects under title XVIII of the Social Security Act for the purpose of providing incentives to home health agencies to furnish remote patient monitoring services that reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 1 of the pilot projects in a State with a population of less than 1,000,000.

(b) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—

(1) IN GENERAL.—The Secretary shall specify the criteria for identifying those Medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section.

(2) CRITERIA.—The criteria specified under paragraph (1)—

(A) shall include conditions and clinical circumstances, including congestive heart failure, diabetes, and chronic pulmonary obstructive disease, and other conditions determined appropriate by the Secretary; and

(B) may provide for the inclusion in the projects of Medicare beneficiaries who begin re-

ceiving home health services under title XVIII of the Social Security Act after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency—

(i) a base expenditure amount equal to the average total payments made under parts A, B, and D of title XVIII of the Social Security Act for Medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk, changes in costs, and growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments made under such parts A, B, and D during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) PAYMENT.—Subject to paragraph (3), the Secretary shall pay to each home health agency participating in a pilot project a payment for each year under the pilot project equal to a 75 percent share of the total Medicare cost savings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented, including any reasonable costs incurred by the Secretary in the administration of the pilot projects.

(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A home health agency that participates in any of the following shall not be eligible to participate in the pilot projects under this section:

(A) A model tested or expanded under section 1115A of the Social Security Act (42 U.S.C. 1315a) that involves shared savings under title XVIII of such Act or any other program or demonstration project that involves such shared savings.

(B) The independence at home medical practice demonstration program under section 1866E of such Act (42 U.S.C. 1395cc–5).

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 3 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the projects. Such report shall contain—

(1) a detailed description of the projects, including any changes in clinical outcomes for Medicare beneficiaries under the projects, Medicare bene-

ficiary satisfaction under the projects, utilization of items and services under parts A, B, and D of title XVIII of the Social Security Act by Medicare beneficiaries under the projects, and Medicare per-beneficiary and Medicare aggregate spending under the projects;

(2) a detailed description of issues related to the expansion of the projects under subsection (f);

(3) recommendations for such legislation and administrative actions as the Secretary considers appropriate; and

(4) other items considered appropriate by the Secretary.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act, the Secretary shall initiate comparable projects in additional areas.

(g) PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO HOME HEALTH AGENCIES.—A payment under this section shall have no effect on the amount of payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services.

(h) STUDY AND REPORT ON THE APPROPRIATE VALUATION FOR REMOTE PATIENT MONITORING SERVICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.—

(1) STUDY.—The Secretary shall conduct a study on the appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) in order to accurately reflect the resources involved in furnishing such services.

(2) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) REMOTE PATIENT MONITORING SERVICES.—

(A) IN GENERAL.—The term ''remote patient monitoring services'' means services furnished in the home using remote patient monitoring technology which—

(i) shall include patient monitoring or patient assessment; and

(ii) may include in-home technology-based professional consultations, patient training services, clinical observation, treatment, and any additional services that utilize technologies specified by the Secretary.

(B) LIMITATION.—The term ''remote patient monitoring services'' shall not include a telecommunication that consists solely of a telephone audio conversation, facsimile, or electronic text mail between a health care professional and a patient.

(3) REMOTE PATIENT MONITORING TECHNOLOGY.—The term ''remote patient monitoring technology'' means a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or information on activities of daily living and may include responses to assessment questions collected on

the devices wirelessly or through a telecommunications connection to a server that complies with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as part of an established plan of care for that patient that includes the review and interpretation of that data by a health care professional.

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

**SEC. 410. COMMUNITY-BASED INSTITUTIONAL SPECIAL NEEDS PLAN DEMONSTRATION PROGRAM.**

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program to prevent and delay institutionalization under Medicaid among targeted low-income Medicare beneficiaries.

(b) ESTABLISHMENT.—The Secretary shall enter into agreements with not more than 5 specialized MA plans for special needs individuals, as defined in section 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(i)), to conduct the CBI-SNP demonstration program. Under the CBI-SNP demonstration

program, a targeted low-income Medicare beneficiary shall receive, as supplemental benefits under section 1852(a)(3) of such Act (42 U.S.C. 1395w-22(a)(3)), long-term care services or supports that—

(1) the Secretary determines appropriate for the purposes of the CBI-SNP demonstration program; and

(2) for which payment may be made under the State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) of the State in which the targeted low-income Medicare beneficiary is located.

(c) ELIGIBLE PLANS.—To be eligible to participate in the CBI-SNP demonstration program, a specialized MA plan for special needs individuals must—

(1) serve special needs individuals (as defined in section 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(i));

(2) have experience in offering special needs plans for nursing home-eligible, non-institutionalized Medicare beneficiaries who live in the community;

(3) be located in a State that the Secretary has determined will participate in the CBI-SNP demonstration program by agreeing to make available data necessary for purposes of conducting the inde-

pendent evaluation required under subsection (f); and

(4) meet such other criteria as the Secretary may require.

(d) TARGETED LOW-INCOME MEDICARE BENEFICIARY DEFINED.—In this section, the term ''targeted low-income Medicare beneficiary'' means a Medicare beneficiary who—

(1) is enrolled in a specialized MA plan for special needs individuals that has been selected to participate in the CBI-SNP demonstration program;

(2) is a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w-114(a)(3)(A)); and

(3) is unable to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986).

(e) IMPLEMENTATION DEADLINE; DURATION.—The CBI-SNP demonstration program shall be implemented not later than January 1, 2016, and shall be conducted for a period of 3 years.

(f) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—Not later than 2 years after the completion of the CBI-SNP demonstration program, the Secretary shall provide

for the evaluation of the CBI-SNP demonstration program by an independent third party. The evaluation shall determine whether the CBI-SNP demonstration program has improved patient care and quality of life for the targeted low-income Medicare beneficiaries participating in the CBI-SNP demonstration program. Specifically, the evaluation shall determine if the CBI-SNP demonstration program has—

(A) reduced hospitalizations or re-hospitalizations;

(B) reduced Medicaid nursing home facility stays; and

(C) reduced spenddown of income and assets for purposes of becoming eligible for Medicaid.

(2) REPORTS.—Not later than 3 years after the completion of the CBI-SNP demonstration program, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations for legislative or administrative action as the Secretary determines appropriate.

(g) FUNDING.—

(1) FUNDING FOR IMPLEMENTATION.—For purposes of carrying out the demonstration program under this section (other than the evaluation and report under subsection (f)), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $3,000,000 to the Centers for Medicare & Medicaid Services Program Management Account.

(2) FUNDING FOR EVALUATION AND REPORT.—For purposes of carrying out the evaluation and report under subsection (f), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under such section 1817 and the Federal Supplementary Medical Insurance Trust Fund under such section 1841, in such proportion as the Secretary determines appropriate, of $500,000.

(3) AVAILABILITY.—Amounts transferred under paragraph (1) or (2) shall remain available until expended.

(h) BUDGET NEUTRALITY.—In conducting the CBI-SNP demonstration program, the Secretary shall ensure

that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been expended under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.) if the CBI-SNP demonstration program had not been implemented.

(i) PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of the CBI-SNP demonstration program under this section.

**SEC. 411. APPLYING CMMI WAIVER AUTHORITY TO PACE IN ORDER TO FOSTER INNOVATIONS.**

(a) CMMI WAIVER AUTHORITY.—Subsection (d)(1) of section 1115A of the Social Security Act (42 U.S.C. 1315a) is amended—

(1) by inserting ''(other than subsections (b)(1)(A) and (c)(5) of section 1894)'' after ''XVIII''; and

(2) by striking ''and 1903(m)(2)(A)(iii)'' and inserting ''1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section)''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Secretary of Health and Human Services should use the waiver authority provided under the amendments made by this section to provide, in a budget

neutral manner, programs of all-inclusive care for the elderly (PACE programs) with increased operational flexibility to support the ability of such programs to improve and innovate and to reduce technical and administrative barriers that have hindered enrollment in such programs.

**SEC. 412. IMPROVE AND MODERNIZE MEDICAID DATA SYSTEMS AND REPORTING.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall implement a strategic plan to increase the usefulness of data about State Medicaid programs reported by States to the Centers for Medicare & Medicaid Services. The strategic plan shall address redundancies and gaps in Medicaid data systems and reporting through improvements to, and modernization of, computer and data systems. Areas for improvement under the plan shall include (but not be limited to) the following:

(1) The reporting of encounter data by managed care plans.

(2) The timeliness and quality of reported data, including enrollment data.

(3) The consistency of data reported from multiple sources.

(4) Information about State program policies.

(b) IMPLEMENTATION STATUS REPORT.—Not later than 1 year after the date of enactment of this Act, the

Secretary of Health and Human Services shall submit a report to Congress on the status of the implementation of the strategic plan required under subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Health and Human Services for the period of fiscal years 2015 through 2019, such sums as may be necessary to carry out this section.

**SEC. 413. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS TRUSTS.**

(a) IN GENERAL.—Section 1917(d)(4)(A) of the Social Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended by inserting ''the individual,'' after ''for the benefit of such individual by''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to trusts established on or after the date of the enactment of this Act.

**SEC. 414. HELPING ENSURE LIFE- AND LIMB-SAVING ACCESS TO PODIATRIC PHYSICIANS.**

(a) INCLUDING PODIATRISTS AS PHYSICIANS UNDER THE MEDICAID PROGRAM.—

(1) IN GENERAL.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1) and (3) of section 1861(r)''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendment made by paragraph (1) shall apply to services furnished on or after the date of enactment of this Act.

(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

(b) MODIFICATIONS TO REQUIREMENTS FOR DIABETIC SHOES TO BE INCLUDED UNDER MEDICAL AND OTHER HEALTH SERVICES UNDER MEDICARE.—

(1) IN GENERAL.—Section 1861(s)(12) of the Social Security Act (42 U.S.C. 1395x(s)(12)) is amended to read as follows:

''(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes (in this paragraph referred to as 'therapeutic shoes') with inserts for an individual with diabetes, if—

''(A) the physician who is managing the individual's diabetic condition—

''(i) documents that the individual has diabetes;

''(ii) certifies that the individual is under a comprehensive plan of care related to the individual's diabetic condition; and

''(iii) documents agreement with the prescribing podiatrist or other qualified physician (as established by the Secretary) that it is medically necessary for the individual to have such extra-depth shoes with inserts or custom molded shoes with inserts;

"(B) the therapeutic shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary) who—

"(i) examines the individual and determines the medical necessity for the individual to receive the therapeutic shoes; and

"(ii) communicates in writing the medical necessity to the physician described in subparagraph (A) for the individual to have therapeutic shoes along with findings that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, previous amputation, or poor circulation; and

"(C) the therapeutic shoes are fitted and furnished by a podiatrist or other qualified supplier (as established by the Secretary), such as a pedorthist or orthotist, who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area);".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to items and services furnished on or after January 1, 2015.

**SEC. 415. DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES.**

(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—

(1) PUBLICATION.—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

(2) REQUIREMENTS.—The criteria published under this subsection shall include criteria with respect to the following:

(A) STAFFING.—Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

(B) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Availability and accessibility of

services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.

(C) CARE COORDINATION.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics.

(D) SCOPE OF SERVICES.—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

(i) Crisis mental health services, including 24-hour mobile crisis teams, emer-

gency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines

contained in the Uniform Mental Health Services Handbook of such Administration.

(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall

issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d).

(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(c) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d).

(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

(d) DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

(2) APPLICATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from

States awarded planning grants under subsection (c).

(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

(i) The target Medicaid population to be served under the demonstration program.

(ii) A list of participating certified community behavioral health clinics.

(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

(vi) Such other information as the Secretary may require relating to the demonstration program including with respect to determining the soundness of the proposed prospective payment system.

(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Not more than 8 States shall be selected for 4-year demonstration programs under this subsection.

(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject

to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

(B) FEDERAL MATCHING PERCENTAGE.—The Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished—

(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

(C) LIMITATIONS.—

(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

(I) that are described in the demonstration program application in accordance with paragraph (2)(B)(iv);

(II) for which payment is available under the State Medicaid program; and

(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

(I) for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; or

(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(6) WAIVER OF STATEWIDENESS REQUIREMENT.—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be necessary to conduct demonstration programs in accordance with the requirements of this subsection.

(7) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

(iii) an assessment of the impact of the demonstration programs on the Fed-

eral and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

(B) RECOMMENDATIONS.—Not later than December 31, 2021, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.

(e) DEFINITIONS.—In this section:

(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms ''Federally-qualified health center services'', ''Federally-qualified health center'', ''rural health clinic services'', and ''rural health clinic'' have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

(2) ENHANCED FMAP.—The term ''enhanced FMAP'' has the meaning given that term in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b) but without regard to the second and third sentences of that section.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(f) FUNDING.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

(A) for purposes of carrying out subsections (a), (b), and (d)(7), $2,000,000 for fiscal year 2014; and

(B) for purposes of awarding planning grants under subsection (c), $25,000,000 for fiscal year 2016.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

**SEC. 416. ANNUAL MEDICAID DSH REPORT.**

Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following:

''(k) ANNUAL REPORT TO CONGRESS.—

''(1) IN GENERAL.—Beginning January 1, 2015, and annually thereafter, the Secretary shall submit a report to Congress on the program established under this section for making payment adjust-

ments to disproportionate share hospitals for the purpose of providing Congress with information relevant to determining an appropriate level of overall funding for such payment adjustments during and after the period in which aggregate reductions in the DSH allotments to States are required under paragraphs (7) and (8) of subsection (f).

''(2) REQUIRED REPORT INFORMATION.—Except as otherwise provided, each report submitted under this subsection shall include the following:

''(A) Information and data relating to changes in the number of uninsured individuals for the most recent year for which such data are available as compared to 2013 and as compared to the Congressional Budget Office estimates of uninsured individuals made at the time of the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152).

''(B) Information and data relating to the extent to which hospitals continue to incur uncompensated care costs from providing unreimbursed or under-reimbursed services to individuals who either are eligible for medical assist-

ance under the State plan under this title or under a waiver of such plan or who have no health insurance (or other source of third party coverage) for such services.

''(C) Information and data relating to the extent to which hospitals continue to provide charity care and unreimbursed or under-reimbursed services, or otherwise incur bad debt, under the program established under this title, the State Children's Health Insurance Program established under title XXI, and State or local indigent care programs, as reported on cost reports submitted under title XVIII or such other data as the Secretary determines appropriate.

''(D) In the first report submitted under this section, a methodology for estimating the amount of unpaid patient deductibles, copayments and coinsurance incurred by hospitals for patients enrolled in qualified health plans through an American Health Benefits Exchange, using existing data and minimizing the administrative burden on hospitals to the extent possible, and in subsequent reports, data regarding such uncompensated care costs collected pursuant to such methodology.

"(E) For each State, information and data relating to the difference between the DSH allotment for the State for the fiscal year that began on October 1 of the year preceding the year in which the report is submitted and the aggregate amount of uncompensated care costs for all disproportionate share hospitals in the State.

"(F) Information and data relating to the extent to which there are certain vital hospital systems that are disproportionately experiencing high levels of uncompensated care and that have multiple other missions, such as a commitment to graduate medical education, the provision of tertiary and trauma care services, providing public health and essential community services, and providing comprehensive, coordinated care.

"(G) Such other information and data relevant to the determination of the level of funding for, and amount of, State DSH allotments as the Secretary determines appropriate

"(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary for the period of fiscal years 2015 through

2109, such sums as may be necessary to carry out this subsection.''.

**SEC. 417. IMPLEMENTATION.**

To the extent the Secretary of Health and Human Services issues a regulation to carry out the provisions of this Act, the Secretary shall, unless otherwise specified in this Act—

(1) issue a notice of proposed rulemaking that includes the proposed regulation;

(2) provide a period of not less than 60 calendar days for comments on the proposed regulation;

(3) not more than 24 months following the date of publication of the proposed rule, publish the final regulation or take alternative action (such as withdrawing the rule or proposing a revised rule with a new comment period) on the proposed regulation; and

(4) not less than 30 days before the effective date of the final regulation, publish the final regulation or take alternative action (such as withdrawing the rule or proposing a revised rule with a new comment period) on the proposed regulation.

**Calendar No. 327**

113TH CONGRESS
2D SESSION

# S. 2110

# A BILL

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

MARCH 12, 2014

Read the second time and placed on the calendar