

**Calendar No. 330**

113TH CONGRESS  
2D SESSION

**S. 2122**

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 12, 2014

Mr. HATCH (for himself, Mr. McCONNELL, and Mr. CORNYN) introduced the following bill; which was read the first time

MARCH 13, 2014

Read the second time and placed on the calendar

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**A BILL**

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

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

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

2 (a) SHORT TITLE.—This Act may be cited as the  
 3 “Responsible Medicare SGR Repeal and Beneficiary Ac-  
 4 cess Improvement Act of 2014”.

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

Sec. 1. Short title; table of contents.

**TITLE I—MEDICARE PAYMENT FOR PHYSICIANS’ SERVICES**

- Sec. 101. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians’ services.
- Sec. 102. Priorities and funding for measure development.
- Sec. 103. Encouraging care management for individuals with chronic care needs.
- Sec. 104. Ensuring accurate valuation of services under the physician fee schedule.
- Sec. 105. Promoting evidence-based care.
- Sec. 106. Empowering beneficiary choices through access to information on physicians’ services.
- Sec. 107. Expanding availability of Medicare data.
- Sec. 108. Reducing administrative burden and other provisions.

**TITLE II—EXTENSIONS**

**Subtitle A—Medicare Extensions**

- Sec. 201. Work geographic adjustment.
- Sec. 202. Medicare payment for therapy services.
- Sec. 203. Medicare ambulance services.
- Sec. 204. Revision of the Medicare-dependent hospital (MDH) program.
- Sec. 205. Revision of Medicare inpatient hospital payment adjustment for low-volume hospitals.
- Sec. 206. Specialized Medicare Advantage plans for special needs individuals.
- Sec. 207. Reasonable cost reimbursement contracts.
- Sec. 208. Quality measure endorsement and selection.
- Sec. 209. Permanent extension of funding outreach and assistance for low-income programs.

**Subtitle B—Medicaid and Other Extensions**

- Sec. 211. Qualifying individual program.
- Sec. 212. Transitional Medical Assistance.
- Sec. 213. Express lane eligibility.
- Sec. 214. Pediatric quality measures.
- Sec. 215. Special diabetes programs.

**Subtitle C—Human Services Extensions**

- Sec. 221. Abstinence education grants.

- Sec. 222. Personal responsibility education program.
- Sec. 223. Family-to-family health information centers.
- Sec. 224. Health workforce demonstration project for low-income individuals.

#### TITLE III—MEDICARE AND MEDICAID PROGRAM INTEGRITY

- Sec. 301. Reducing improper Medicare payments.
- Sec. 302. Authority for Medicaid fraud control units to investigate and prosecute complaints of abuse and neglect of Medicaid patients in home and community-based settings.
- Sec. 303. Improved use of funds received by the HHS Inspector General from oversight and investigative activities.
- Sec. 304. Preventing and reducing improper Medicare and Medicaid expenditures.

#### TITLE IV—OTHER PROVISIONS

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

#### TITLE V—RESTORING INDIVIDUAL LIBERTY

- Sec. 501. Restoring individual liberty.

1     **TITLE I—MEDICARE PAYMENT**  
 2     **FOR PHYSICIANS’ SERVICES**

3     **SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE**  
 4                     **(SGR) AND IMPROVING MEDICARE PAYMENT**  
 5                     **FOR PHYSICIANS’ SERVICES.**

6             (a) STABILIZING FEE UPDATES.—

7                     (1) REPEAL OF SGR PAYMENT METHOD-  
 8             OLOGY.—Section 1848 of the Social Security Act  
 9             (42 U.S.C. 1395w–4) is amended—

10                     (A) in subsection (d)—

11                             (i) in paragraph (1)(A), by inserting  
 12                     “or a subsequent paragraph” after “para-  
 13                     graph (4)”;

14                             (ii) in paragraph (4)—

15                                     (I) in the heading, by inserting  
 16                     “AND ENDING WITH 2013” after  
 17                     “YEARS BEGINNING WITH 2001”; and

18                                     (II) in subparagraph (A), by in-  
 19                     serting “and ending with 2013” after  
 20                     “a year beginning with 2001”; and

21                     (B) in subsection (f)—

22                             (i) in paragraph (1)(B), by inserting  
 23                     “through 2013” after “of each succeeding  
 24                     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 per-  
cent.”.

(3) MEDPAC REPORTS.—

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

(i) physician and other health profes-  
sional utilization and expenditures (and the  
rate of increase of such utilization and ex-  
penditures) 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 de-  
scribe such relationship and the impact of  
changes in such physician and other health pro-  
fessional practice and service ordering patterns  
on total utilization and expenditures under  
parts A, B, and D of such title.

1 (B) FINAL REPORT.—Not later than July  
2 1, 2020, the Medicare Payment Advisory Com-  
3 mission shall submit to Congress a report on  
4 the relationship described in subparagraph (A),  
5 including the results determined from applying  
6 the methodology included in the report sub-  
7 mitted under such subparagraph.

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

13 (i) the payment update for profes-  
14 sional services applied under the Medicare  
15 program under title XVIII of the Social  
16 Security Act for the period of years 2014  
17 through 2018;

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

21 (iii) the effect of such update on en-  
22 suring a sufficient number of providers to  
23 maintain access to care by Medicare bene-  
24 ficiaries; and

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

6 (b) CONSOLIDATION OF CERTAIN CURRENT LAW  
 7 PERFORMANCE PROGRAMS WITH NEW MERIT-BASED IN-  
 8 CENTIVE PAYMENT SYSTEM.—

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

11 (A) SUNSETTING SEPARATE MEANINGFUL  
 12 USE PAYMENT ADJUSTMENTS.—Section  
 13 1848(a)(7)(A) of the Social Security Act (42  
 14 U.S.C. 1395w-4(a)(7)(A)) is amended—

15 (i) in clause (i), by striking “2015 or  
 16 any subsequent payment year” and insert-  
 17 ing “2015, 2016, or 2017”;

18 (ii) in clause (ii)—

19 (I) in the matter preceding sub-  
 20 clause (I), by striking “Subject to  
 21 clause (iii), for” and inserting “For”;  
 22 and

23 (II) in subclause (III), by strik-  
 24 ing “and each subsequent year”; and  
 25 (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 pe-  
 riod 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 PUR-  
 POSES OF MIPS.—With respect to 2018 and  
 each subsequent payment year, the Secretary  
 shall, for purposes of subsection (q) and in ac-  
 cordance with paragraph (1)(F) of such sub-  
 section, determine whether an eligible profes-  
 sional who is a MIPS eligible professional (as  
 defined in subsection (q)(1)(C)) for such year is

1 a meaningful EHR user under this paragraph  
 2 for the performance period under subsection (q)  
 3 for such year.”.

4 (2) QUALITY REPORTING.—

5 (A) SUNSETTING SEPARATE QUALITY RE-  
 6 PORTING INCENTIVES.—Section 1848(a)(8)(A)  
 7 of the Social Security Act (42 U.S.C. 1395w-  
 8 4(a)(8)(A)) is amended—

9 (i) in clause (i), by striking “2015 or  
 10 any subsequent year” and inserting “2015,  
 11 2016, or 2017”; and

12 (ii) in clause (ii)(II), by striking “and  
 13 each subsequent year” and inserting “and  
 14 2017”.

15 (B) CONTINUATION OF QUALITY MEAS-  
 16 URES AND PROCESSES FOR MIPS.—Section  
 17 1848 of the Social Security Act (42 U.S.C.  
 18 1395w-4) is amended—

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

21 “(9) CONTINUED APPLICATION FOR PURPOSES  
 22 OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUN-  
 23 TEERING TO REPORT.—The Secretary shall, in ac-  
 24 cordance with subsection (q)(1)(F), carry out the  
 25 provisions of this subsection—

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

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

5 (ii) in subsection (m)—

6 (I) by redesignating paragraph  
7 (7) added by section 10327(a) of Pub-  
8 lic Law 111–148 as paragraph (8);  
9 and

10 (II) by adding at the end the fol-  
11 lowing new paragraph:

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

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

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

21 (3) VALUE-BASED PAYMENTS.—

22 (A) SUNSETTING SEPARATE VALUE-BASED  
23 PAYMENTS.—Clause (iii) of section  
24 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 estab-  
lished under this subsection for items and  
services furnished on or after January 1,  
2015, but before January 1, 2018, with re-  
spect to specific physicians and groups of  
physicians the Secretary determines appro-  
priate. Such payment modifier shall not be  
applied for items and services furnished on  
or after January 1, 2018.”.

(B) CONTINUATION OF VALUE-BASED PAY-  
MENT 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 PUR-  
POSES OF MIPS.—The Secretary shall, in ac-  
cordance 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

1                   and each subsequent year, the Secretary  
 2                   shall, in accordance with subsection  
 3                   (q)(1)(F), carry out this paragraph for  
 4                   purposes of subsection (q).”.

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

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

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

10                   “(1) ESTABLISHMENT.—

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

17                   “(i) develop a methodology for assess-  
 18                   ing the total performance of each MIPS el-  
 19                   igible professional according to perform-  
 20                   ance standards under paragraph (3) for a  
 21                   performance period (as established under  
 22                   paragraph (4)) for a year;

23                   “(ii) using such methodology, provide  
 24                   for a composite performance score in ac-  
 25                   cordance 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 determine 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 spe-

1 cialist (as such terms are defined in  
 2 section 1861(aa)(5)), and a certified  
 3 registered nurse anesthetist (as de-  
 4 fined in section 1861(bb)(2)) and a  
 5 group that includes such profes-  
 6 sionals; and

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

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

23 “(I) is a qualifying APM partici-  
 24 pant (as defined in section  
 25 1833(z)(2));

1 “(II) subject to clause (vii), is a  
 2 partial qualifying APM participant (as  
 3 defined in clause (iii)) for the most re-  
 4 cent period for which data are avail-  
 5 able and who, for the performance pe-  
 6 riod with respect to such year, does  
 7 not report on applicable measures and  
 8 activities described in paragraph  
 9 (2)(B) that are required to be re-  
 10 ported by such a professional under  
 11 the MIPS; or

12 “(III) for the performance period  
 13 with respect to such year, does not ex-  
 14 ceed the low-volume threshold meas-  
 15 urement selected under clause (iv).

16 “(iii) PARTIAL QUALIFYING APM PAR-  
 17 TICIPANT.—For purposes of this subpara-  
 18 graph, the term ‘partial qualifying APM  
 19 participant’ means, with respect to a year,  
 20 an eligible professional for whom the Sec-  
 21 retary determines the minimum payment  
 22 percentage (or percentages), as applicable,  
 23 described in paragraph (2) of section  
 24 1833(z) for such year have not been satis-  
 25 fied, but who would be considered a quali-



1           fying APM participant (as defined in such  
2           paragraph) for such year if—

3                   “(I) with respect to 2018 and  
4                   2019, the reference in subparagraph  
5                   (A) of such paragraph to 25 percent  
6                   was instead a reference to 20 percent;

7                   “(II) with respect to 2020 and  
8                   2021—

9                           “(aa) the reference in sub-  
10                          paragraph (B)(i) of such para-  
11                          graph to 50 percent was instead  
12                          a reference to 40 percent; and

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

19                   “(III) with respect to 2022 and  
20                   subsequent years—

21                           “(aa) the reference in sub-  
22                          paragraph (C)(i) of such para-  
23                          graph to 75 percent was instead  
24                          a reference to 50 percent; and

1 “(bb) the references in sub-  
 2 paragraph (C)(ii) of such para-  
 3 graph to 75 percent and 25 per-  
 4 cent of such paragraph were in-  
 5 stead references to 50 percent  
 6 and 20 percent, respectively.

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

13 “(I) The minimum number (as  
 14 determined by the Secretary) of indi-  
 15 viduals enrolled under this part who  
 16 are treated by the eligible professional  
 17 for the performance period involved.

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

23 “(III) The minimum amount (as  
 24 determined by the Secretary) of al-  
 25 lowed charges billed by such profes-

1           sional under this part for such per-  
2           formance period.

3           “(v) TREATMENT OF NEW MEDICARE  
4           ENROLLED ELIGIBLE PROFESSIONALS.—In  
5           the case of a professional who first be-  
6           comes a Medicare enrolled eligible profes-  
7           sional during the performance period for a  
8           year (and had not previously submitted  
9           claims under this title such as a person, an  
10          entity, or a part of a physician group or  
11          under a different billing number or tax  
12          identifier), such professional shall not be  
13          treated under this subsection as a MIPS  
14          eligible professional until the subsequent  
15          year and performance period for such sub-  
16          sequent year.

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

1 “(vii) PARTIAL QUALIFYING APM PAR-  
2 TICIPANT CLARIFICATIONS.—

3 “(I) TREATMENT AS MIPS ELIGI-  
4 BLE PROFESSIONAL.—In the case of  
5 an eligible professional who is a par-  
6 tial qualifying APM participant, with  
7 respect to a year, and who for the  
8 performance period for such year re-  
9 ports on applicable measures and ac-  
10 tivities described in paragraph (2)(B)  
11 that are required to be reported by  
12 such a professional under the MIPS,  
13 such eligible professional is considered  
14 to be a MIPS eligible professional  
15 with respect to such year.

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

1 payment under paragraph (1) of such  
2 section for such year.

3 “(D) APPLICATION TO GROUP PRAC-  
4 TICES.—

5 “(i) IN GENERAL.—Under the MIPS:

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

16 “(II) OTHER PERFORMANCE CAT-  
17 EGORIES.—The Secretary may estab-  
18 lish and apply a process that includes  
19 features of the provisions of sub-  
20 section (m)(3)(C) for MIPS eligible  
21 professionals in a group practice with  
22 respect to assessing the performance  
23 of such group with respect to the per-  
24 formance categories described in

1 clauses (ii) through (iv) of such para-  
 2 graph.

3 “(ii) ENSURING COMPREHENSIVENESS  
 4 OF GROUP PRACTICE ASSESSMENT.—The  
 5 process established under clause (i) shall to  
 6 the extent practicable reflect the range of  
 7 items and services furnished by the MIPS  
 8 eligible professionals in the group practice  
 9 involved.

10 “(iii) CLARIFICATION.—MIPS eligible  
 11 professionals electing to be a virtual group  
 12 under paragraph (5)(I) shall not be consid-  
 13 ered MIPS eligible professionals in a group  
 14 practice for purposes of applying this sub-  
 15 paragraph.

16 “(E) USE OF REGISTRIES.—Under the  
 17 MIPS, the Secretary shall encourage the use of  
 18 qualified clinical data registries pursuant to  
 19 subsection (m)(3)(E) in carrying out this sub-  
 20 section.

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

1 “(i) adjust the application of such  
2 provision to ensure the provision is con-  
3 sistent with the provisions of this sub-  
4 section; and

5 “(ii) not apply such provision to the  
6 extent that the provision is duplicative with  
7 a provision of this subsection.

8 “(G) ACCOUNTING FOR RISK FACTORS.—

9 “(i) RISK FACTORS.—Taking into ac-  
10 count the relevant studies conducted and  
11 recommendations made in reports under  
12 section 101(f)(1) of the Responsible Medi-  
13 care SGR Repeal and Beneficiary Access  
14 Improvement Act of 2014, the Secretary,  
15 on an ongoing basis, shall estimate how an  
16 individual’s health status and other risk  
17 factors affect quality and resource use out-  
18 come measures and, as feasible, shall in-  
19 corporate information from quality and re-  
20 source use outcome measurement (includ-  
21 ing care episode and patient condition  
22 groups) into the MIPS.

23 “(ii) ACCOUNTING FOR OTHER FAC-  
24 TORS IN PAYMENT ADJUSTMENTS.—Tak-  
25 ing into account the studies conducted and

recommendations made in reports under section 101(f)(1) of the Responsible 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, composite 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.



1 “(iv) Meaningful use of certified EHR  
2 technology.

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

9 “(i) QUALITY.—For the performance  
10 category described in subparagraph (A)(i),  
11 the quality measures included in the final  
12 measures list published under subpara-  
13 graph (D)(i) for such year and the list of  
14 quality measures described in subpara-  
15 graph (D)(vi) used by qualified clinical  
16 data registries under subsection (m)(3)(E).

17 “(ii) RESOURCE USE.—For the per-  
18 formance category described in subpara-  
19 graph (A)(ii), the measurement of resource  
20 use for such period under subsection  
21 (p)(3), using the methodology under sub-  
22 section (r) as appropriate, and, as feasible  
23 and applicable, accounting for the cost of  
24 drugs under part D.

1 “(iii) CLINICAL PRACTICE IMPROVE-  
2 MENT ACTIVITIES.—For the performance  
3 category described in subparagraph  
4 (A)(iii), clinical practice improvement ac-  
5 tivities (as defined in subparagraph  
6 (C)(v)(III)) under subcategories specified  
7 by the Secretary for such period, which  
8 shall include at least the following:

9 “(I) The subcategory of expanded  
10 practice access, which shall include ac-  
11 tivities such as same day appoint-  
12 ments for urgent needs and after  
13 hours access to clinician advice.

14 “(II) The subcategory of popu-  
15 lation management, which shall in-  
16 clude activities such as monitoring  
17 health conditions of individuals to pro-  
18 vide timely health care interventions  
19 or participation in a qualified clinical  
20 data registry.

21 “(III) The subcategory of care  
22 coordination, which shall include ac-  
23 tivities such as timely communication  
24 of test results, timely exchange of  
25 clinical information to patients and

1 other providers, and use of remote  
2 monitoring or telehealth.

3 “(IV) The subcategory of bene-  
4 ficiary engagement, which shall in-  
5 clude activities such as the establish-  
6 ment of care plans for individuals  
7 with complex care needs, beneficiary  
8 self-management assessment and  
9 training, and using shared decision-  
10 making mechanisms.

11 “(V) The subcategory of patient  
12 safety and practice assessment, such  
13 as through use of clinical or surgical  
14 checklists and practice assessments  
15 related to maintaining certification.

16 “(VI) The subcategory of partici-  
17 pation in an alternative payment  
18 model (as defined in section  
19 1833(z)(3)(C)).

20 In establishing activities under this clause,  
21 the Secretary shall give consideration to  
22 the circumstances of small practices (con-  
23 sisting of 15 or fewer professionals) and  
24 practices located in rural areas and in  
25 health professional shortage areas (as des-

1           ignated under section 332(a)(1)(A) of the  
2           Public Health Service Act).

3           “(iv) MEANINGFUL EHR USE.—For  
4           the performance category described in sub-  
5           paragraph (A)(iv), the requirements estab-  
6           lished for such period under subsection  
7           (o)(2) for determining whether an eligible  
8           professional is a meaningful EHR user.

9           “(C) ADDITIONAL PROVISIONS.—

10          “(i) EMPHASIZING OUTCOME MEAS-  
11          URES UNDER THE QUALITY PERFORMANCE  
12          CATEGORY.—In applying subparagraph  
13          (B)(i), the Secretary shall, as feasible, em-  
14          phasize the application of outcome meas-  
15          ures.

16          “(ii) APPLICATION OF ADDITIONAL  
17          SYSTEM MEASURES.—The Secretary may  
18          use measures used for a payment system  
19          other than for physicians, such as meas-  
20          ures for inpatient hospitals, for purposes of  
21          the performance categories described in  
22          clauses (i) and (ii) of subparagraph (A).  
23          For purposes of the previous sentence, the  
24          Secretary may not use measures for hos-

1           pital outpatient departments, except in the  
2           case of emergency physicians.

3           “(iii) GLOBAL AND POPULATION-  
4           BASED MEASURES.—The Secretary may  
5           use global measures, such as global out-  
6           come measures, and population-based  
7           measures for purposes of the performance  
8           category described in subparagraph (A)(i).

9           “(iv) APPLICATION OF MEASURES AND  
10          ACTIVITIES TO NON-PATIENT-FACING PRO-  
11          FESSIONALS.—In carrying out this para-  
12          graph, with respect to measures and activi-  
13          ties specified in subparagraph (B) for per-  
14          formance categories described in subpara-  
15          graph (A), the Secretary—

16               “(I) shall give consideration to  
17               the circumstances of professional  
18               types (or subcategories of those types  
19               determined by practice characteris-  
20               tics) who typically furnish services  
21               that do not involve face-to-face inter-  
22               action with a patient; and

23               “(II) may, to the extent feasible  
24               and appropriate, take into account  
25               such circumstances and apply under

1           this subsection with respect to MIPS  
 2           eligible professionals of such profes-  
 3           sional types or subcategories, alter-  
 4           native measures or activities that ful-  
 5           fill the goals of the applicable per-  
 6           formance category.

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

10           “(v) CLINICAL PRACTICE IMPROVE-  
 11           MENT ACTIVITIES.—

12                   “(I) REQUEST FOR INFORMA-  
 13                   TION.—In initially applying subpara-  
 14                   graph (B)(iii), the Secretary shall use  
 15                   a request for information to solicit  
 16                   recommendations from stakeholders to  
 17                   identify activities described in such  
 18                   subparagraph and specifying criteria  
 19                   for such activities.

20                   “(II) CONTRACT AUTHORITY FOR  
 21                   CLINICAL PRACTICE IMPROVEMENT  
 22                   ACTIVITIES PERFORMANCE CAT-  
 23                   EGORY.—In applying subparagraph  
 24                   (B)(iii), the Secretary may contract

1 with entities to assist the Secretary  
2 in—

3 “(aa) identifying activities  
4 described in subparagraph  
5 (B)(iii);

6 “(bb) specifying criteria for  
7 such activities; and

8 “(cc) determining whether a  
9 MIPS eligible professional meets  
10 such criteria.

11 “(III) CLINICAL PRACTICE IM-  
12 PROVEMENT ACTIVITIES DEFINED.—

13 For purposes of this subsection, the  
14 term ‘clinical practice improvement  
15 activity’ means an activity that rel-  
16 evant eligible professional organiza-  
17 tions and other relevant stakeholders  
18 identify as improving clinical practice  
19 or care delivery and that the Sec-  
20 retary determines, when effectively ex-  
21 ecuted, is likely to result in improved  
22 outcomes.

23 “(D) ANNUAL LIST OF QUALITY MEASURES  
24 AVAILABLE FOR MIPS ASSESSMENT.—

1 “(i) IN GENERAL.—Under the MIPS,  
2 the Secretary, through notice and comment  
3 rulemaking and subject to the succeeding  
4 clauses of this subparagraph, shall, with  
5 respect to the performance period for a  
6 year, establish an annual final list of qual-  
7 ity measures from which MIPS eligible  
8 professionals may choose for purposes of  
9 assessment under this subsection for such  
10 performance period. Pursuant to the pre-  
11 vious sentence, the Secretary shall—

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

18 “(II) not later than November 1  
19 of the year prior to the first day of  
20 each subsequent performance period,  
21 update the final list of quality meas-  
22 ures from the previous year (and pub-  
23 lish such updated final list in the Fed-  
24 eral Register), by—



1                   “(aa) removing from such  
 2 list, as appropriate, quality meas-  
 3 ures, which may include the re-  
 4 moval of measures that are no  
 5 longer meaningful (such as meas-  
 6 ures that are topped out);

7                   “(bb) adding to such list, as  
 8 appropriate, new quality meas-  
 9 ures; and

10                   “(cc) determining whether  
 11 or not quality measures on such  
 12 list that have undergone sub-  
 13 stantive changes should be in-  
 14 cluded in the updated list.

15                   “(ii) CALL FOR QUALITY MEAS-  
 16 URES.—

17                   “(I) IN GENERAL.—Eligible pro-  
 18 fessional organizations and other rel-  
 19 evant stakeholders shall be requested  
 20 to identify and submit quality meas-  
 21 ures to be considered for selection  
 22 under this subparagraph in the an-  
 23 nual list of quality measures published  
 24 under clause (i) and to identify and  
 25 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 se-

1                   lection of measures under subsections  
2                   (k), (m), and (p)(2).

3                   “(iv) PEER REVIEW.—Before includ-  
4                   ing a new measure or a measure described  
5                   in clause (i)(II)(cc) in the final list of  
6                   measures published under clause (i) for a  
7                   year, the Secretary shall submit for publi-  
8                   cation in applicable specialty-appropriate  
9                   peer-reviewed journals such measure and  
10                  the method for developing and selecting  
11                  such measure, including clinical and other  
12                  data supporting such measure.

13                  “(v) MEASURES FOR INCLUSION.—  
14                  The final list of quality measures published  
15                  under clause (i) shall include, as applica-  
16                  ble, measures under subsections (k), (m),  
17                  and (p)(2), including quality measures  
18                  from among—

19                         “(I) measures endorsed by a con-  
20                         sensus-based entity;

21                         “(II) measures developed under  
22                         subsection (s); and

23                         “(III) measures submitted under  
24                         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—

1 “(I) shall not be subject to the  
 2 requirements under clause (i) (except  
 3 under items (aa) and (cc) of subclause  
 4 (II) of such clause) or to the require-  
 5 ment under clause (iv); and

6 “(II) shall be included in the  
 7 final list of quality measures pub-  
 8 lished under clause (i) unless removed  
 9 under clause (i)(II)(aa).

10 “(viii) CONSULTATION WITH REL-  
 11 EVANT ELIGIBLE PROFESSIONAL ORGANI-  
 12 ZATIONS AND OTHER RELEVANT STAKE-  
 13 HOLDERS.—Relevant eligible professional  
 14 organizations and other relevant stake-  
 15 holders, including State and national med-  
 16 ical societies, shall be consulted in carrying  
 17 out this subparagraph.

18 “(ix) OPTIONAL APPLICATION.—The  
 19 process under section 1890A is not re-  
 20 quired to apply to the selection of meas-  
 21 ures under this subparagraph.

22 “(3) PERFORMANCE STANDARDS.—

23 “(A) ESTABLISHMENT.—Under the MIPS,  
 24 the Secretary shall establish performance stand-  
 25 ards with respect to measures and activities

1 specified under paragraph (2)(B) for a perform-  
 2 ance period (as established under paragraph  
 3 (4)) for a year.

4 “(B) CONSIDERATIONS IN ESTABLISHING  
 5 STANDARDS.—In establishing such performance  
 6 standards with respect to measures and activi-  
 7 ties specified under paragraph (2)(B), the Sec-  
 8 retary shall consider the following:

9 “(i) Historical performance standards.

10 “(ii) Improvement.

11 “(iii) The opportunity for continued  
 12 improvement.

13 “(4) PERFORMANCE PERIOD.—The Secretary  
 14 shall establish a performance period (or periods) for  
 15 a year (beginning with the year described in para-  
 16 graph (1)(B)). Such performance period (or periods)  
 17 shall begin and end prior to the beginning of such  
 18 year and be as close as possible to such year. In this  
 19 subsection, such performance period (or periods) for  
 20 a year shall be referred to as the performance period  
 21 for the year.

22 “(5) COMPOSITE PERFORMANCE SCORE.—

23 “(A) IN GENERAL.—Subject to the suc-  
 24 ceeding provisions of this paragraph and taking  
 25 into account, as available and applicable, para-

graph (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 profes-

1           sional who fails to report on an applicable  
2           measure or activity that is required to be  
3           reported by the professional, the profes-  
4           sional shall be treated as achieving the  
5           lowest potential score applicable to such  
6           measure or activity.

7           “(ii) ENCOURAGING USE OF CER-  
8           TIFIED EHR TECHNOLOGY AND QUALIFIED  
9           CLINICAL DATA REGISTRIES FOR REPORT-  
10          ING QUALITY MEASURES.—Under the  
11          methodology established under subpara-  
12          graph (A), the Secretary shall—

13               “(I) encourage MIPS eligible  
14               professionals to report on applicable  
15               measures with respect to the perform-  
16               ance category described in paragraph  
17               (2)(A)(i) through the use of certified  
18               EHR technology and qualified clinical  
19               data registries; and

20               “(II) with respect to a perform-  
21               ance period, with respect to a year,  
22               for which a MIPS eligible professional  
23               reports such measures through the  
24               use of such EHR technology, treat  
25               such professional as satisfying the



1 clinical quality measures reporting re-  
2 quirement described in subsection  
3 (o)(2)(A)(iii) for such year.

4 “(C) CLINICAL PRACTICE IMPROVEMENT  
5 ACTIVITIES PERFORMANCE SCORE.—

6 “(i) RULE FOR ACCREDITATION.—A  
7 MIPS eligible professional who is in a  
8 practice that is certified as a patient-cen-  
9 tered medical home or comparable spe-  
10 cialty practice pursuant to subsection  
11 (b)(8)(B)(i) with respect to a performance  
12 period shall be given the highest potential  
13 score for the performance category de-  
14 scribed in paragraph (2)(A)(iii) for such  
15 period.

16 “(ii) APM PARTICIPATION.—Partici-  
17 pation by a MIPS eligible professional in  
18 an alternative payment model (as defined  
19 in section 1833(z)(3)(C)) with respect to a  
20 performance period shall earn such eligible  
21 professional a minimum score of one-half  
22 of the highest potential score for the per-  
23 formance category described in paragraph  
24 (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 cat-

1                   egories, may take into account the im-  
 2                   provement of the professional.

3                   “(ii) ASSIGNING HIGHER WEIGHT FOR  
 4                   ACHIEVEMENT.—Beginning with the  
 5                   fourth year to which the MIPS applies,  
 6                   under the methodology developed under  
 7                   subparagraph (A), the Secretary may as-  
 8                   sign a higher scoring weight under sub-  
 9                   paragraph (F) with respect to the achieve-  
 10                  ment of a MIPS eligible professional than  
 11                  with respect to any improvement of such  
 12                  professional applied under clause (i) with  
 13                  respect to a measure, activity, or category  
 14                  described in paragraph (2).

15                  “(E) WEIGHTS FOR THE PERFORMANCE  
 16                  CATEGORIES.—

17                  “(i) IN GENERAL.—Under the meth-  
 18                  odology developed under subparagraph (A),  
 19                  subject to subparagraph (F)(i) and clauses  
 20                  (ii) and (iii), the composite performance  
 21                  score shall be determined as follows:

22                          “(I) QUALITY.—

23                                  “(aa) IN GENERAL.—Sub-  
 24                                  ject to item (bb), thirty percent  
 25                                  of such score shall be based on

1 performance with respect to the  
2 category described in clause (i) of  
3 paragraph (2)(A). In applying  
4 the previous sentence, the Sec-  
5 retary shall, as feasible, encour-  
6 age the application of outcome  
7 measures within such category.

8 “(bb) FIRST 2 YEARS.—For  
9 the first and second years for  
10 which the MIPS applies to pay-  
11 ments, the percentage applicable  
12 under item (aa) shall be in-  
13 creased in a manner such that  
14 the total percentage points of the  
15 increase under this item for the  
16 respective year equals the total  
17 number of percentage points by  
18 which the percentage applied  
19 under subclause (II)(bb) for the  
20 respective year is less than 30  
21 percent.

22 “(II) RESOURCE USE.—

23 “(aa) IN GENERAL.—Sub-  
24 ject to item (bb), thirty percent  
25 of such score shall be based on

1 performance with respect to the  
2 category described in clause (ii)  
3 of paragraph (2)(A).

4 “(bb) FIRST 2 YEARS.—For  
5 the first year for which the MIPS  
6 applies to payments, not more  
7 than 10 percent of such score  
8 shall be based on performance  
9 with respect to the category de-  
10 scribed in clause (ii) of para-  
11 graph (2)(A). For the second  
12 year for which the MIPS applies  
13 to payments, not more than 15  
14 percent of such score shall be  
15 based on performance with re-  
16 spect to the category described in  
17 clause (ii) of paragraph (2)(A).

18 “(III) CLINICAL PRACTICE IM-  
19 PROVEMENT ACTIVITIES.—Fifteen  
20 percent of such score shall be based  
21 on performance with respect to the  
22 category described in clause (iii) of  
23 paragraph (2)(A).

24 “(IV) MEANINGFUL USE OF CER-  
25 TIFIED EHR TECHNOLOGY.—Twenty-

1           five percent of such score shall be  
2           based on performance with respect to  
3           the category described in clause (iv) of  
4           paragraph (2)(A).

5           “(ii) AUTHORITY TO ADJUST PER-  
6           CENTAGES IN CASE OF HIGH EHR MEAN-  
7           INGFUL USE ADOPTION.—In any year in  
8           which the Secretary estimates that the pro-  
9           portion of eligible professionals (as defined  
10          in subsection (o)(5)) who are meaningful  
11          EHR users (as determined under sub-  
12          section (o)(2)) is 75 percent or greater, the  
13          Secretary may reduce the percent applica-  
14          ble under clause (i)(IV), but not below 15  
15          percent. If the Secretary makes such re-  
16          duction for a year, subject to subclauses  
17          (I)(bb) and (II)(bb) of clause (i), the per-  
18          centages applicable under one or more of  
19          subclauses (I), (II), and (III) of clause (i)  
20          for such year shall be increased in a man-  
21          ner such that the total percentage points  
22          of the increase under this clause for such  
23          year equals the total number of percentage  
24          points reduced under the preceding sen-  
25          tence for such year.

1                   “(F)     CERTAIN     FLEXIBILITY     FOR  
 2                   WEIGHTING PERFORMANCE CATEGORIES, MEAS-  
 3                   URES, AND ACTIVITIES.—Under the method-  
 4                   ology under subparagraph (A), if there are not  
 5                   sufficient measures and clinical practice im-  
 6                   provement activities applicable and available to  
 7                   each type of eligible professional involved, the  
 8                   Secretary shall assign different scoring weights  
 9                   (including a weight of 0)—

10                   “(i) which may vary from the scoring  
 11                   weights specified in subparagraph (E), for  
 12                   each performance category based on the  
 13                   extent to which the category is applicable  
 14                   to the type of eligible professional involved;  
 15                   and

16                   “(ii) for each measure and activity  
 17                   specified under paragraph (2)(B) with re-  
 18                   spect to each such category based on the  
 19                   extent to which the measure or activity is  
 20                   applicable and available to the type of eli-  
 21                   gible professional involved.

22                   “(G)     RESOURCE     USE.—Analysis of the  
 23                   performance category described in paragraph  
 24                   (2)(A)(ii) shall include results from the method-

ology 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



1 applied to each such professional in  
2 such group for such performance pe-  
3 riod shall be with respect to the com-  
4 bined performance of all such profes-  
5 sionals in such group for such period;  
6 and

7 “(II) the composite score pro-  
8 vided under this paragraph for such  
9 performance period with respect to  
10 each such performance category for  
11 each such MIPS eligible professional  
12 in such virtual group shall be based  
13 on the assessment of the combined  
14 performance under subclause (I) for  
15 the performance category and per-  
16 formance period.

17 “(ii) ELECTION OF PRACTICES TO BE  
18 A VIRTUAL GROUP.—The Secretary shall,  
19 in accordance with clause (iii), establish  
20 and have in place a process to allow an in-  
21 dividual MIPS eligible professional or a  
22 group practice consisting of not more than  
23 10 MIPS eligible professionals to elect,  
24 with respect to a performance period for a  
25 year, for such individual MIPS eligible pro-

1 professional or all such MIPS eligible profes-  
2 sionals in such group practice, respectively,  
3 to be a virtual group under this subpara-  
4 graph with at least one other such indi-  
5 vidual MIPS eligible professional or group  
6 practice making such an election. Such a  
7 virtual group may be based on geographic  
8 areas or on provider specialties defined by  
9 nationally recognized multispecialty boards  
10 of certification or equivalent certification  
11 boards and such other eligible professional  
12 groupings in order to capture classifica-  
13 tions of providers across eligible profes-  
14 sional organizations and other practice  
15 areas or categories.

16 “(iii) REQUIREMENTS.—The process  
17 under clause (ii)—

18 “(I) shall provide that an election  
19 under such clause, with respect to a  
20 performance period, shall be made be-  
21 fore or during the beginning of such  
22 performance period and may not be  
23 changed during such performance pe-  
24 riod;

1 “(II) shall provide that a practice  
 2 described in such clause, and each  
 3 MIPS eligible professional in such  
 4 practice, may elect to be in no more  
 5 than one virtual group for a perform-  
 6 ance period; and

7 “(III) may provide that a virtual  
 8 group may be combined at the tax  
 9 identification number level.

10 “(6) MIPS PAYMENTS.—

11 “(A) MIPS ADJUSTMENT FACTOR.—Tak-  
 12 ing into account paragraph (1)(G), the Sec-  
 13 retary shall specify a MIPS adjustment factor  
 14 for each MIPS eligible professional for a year.  
 15 Such MIPS adjustment factor for a MIPS eligi-  
 16 ble professional for a year shall be in the form  
 17 of a percent and shall be determined—

18 “(i) by comparing the composite per-  
 19 formance score of the eligible professional  
 20 for such year to the performance threshold  
 21 established under subparagraph (D)(i) for  
 22 such year;

23 “(ii) in a manner such that the ad-  
 24 justment factors specified under this sub-  
 25 paragraph for a year result in differential

1 payments under this paragraph reflecting  
2 that—

3 “(I) MIPS eligible professionals  
4 with composite performance scores for  
5 such year at or above such perform-  
6 ance threshold for such year receive  
7 zero or positive incentive payment ad-  
8 justment factors for such year in ac-  
9 cordance with clause (iii), with such  
10 professionals having higher composite  
11 performance scores receiving higher  
12 adjustment factors; and

13 “(II) MIPS eligible professionals  
14 with composite performance scores for  
15 such year below such performance  
16 threshold for such year receive nega-  
17 tive payment adjustment factors for  
18 such year in accordance with clause  
19 (iv), with such professionals having  
20 lower composite performance scores  
21 receiving lower adjustment factors;

22 “(iii) in a manner such that MIPS eli-  
23 gible professionals with composite scores  
24 described in clause (ii)(I) for such year,  
25 subject to clauses (i) and (ii) of subpara-

graph (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  $\frac{1}{4}$  of the per-

1                   formance threshold specified under  
 2                   subparagraph (D)(i) for such year, re-  
 3                   ceive a negative payment adjustment  
 4                   factor that is equal to the negative of  
 5                   the applicable percent specified in  
 6                   subparagraph (B) for such year.

7                   “(B) APPLICABLE PERCENT DEFINED.—  
 8                   For purposes of this paragraph, the term ‘ap-  
 9                   plicable percent’ means—

10                   “(i) for 2018, 4 percent;

11                   “(ii) for 2019, 5 percent;

12                   “(iii) for 2020, 7 percent; and

13                   “(iv) for 2021 and subsequent years,  
 14                   9 percent.

15                   “(C) ADDITIONAL MIPS ADJUSTMENT FAC-  
 16                   TORS FOR EXCEPTIONAL PERFORMANCE.—

17                   “(i) IN GENERAL.—In the case of a  
 18                   MIPS eligible professional with a com-  
 19                   posite performance score for a year at or  
 20                   above the additional performance threshold  
 21                   under subparagraph (D)(ii) for such year,  
 22                   in addition to the MIPS adjustment factor  
 23                   under subparagraph (A) for the eligible  
 24                   professional for such year, subject to the  
 25                   availability of funds under clause (ii), the

1 Secretary shall specify an additional posi-  
 2 tive MIPS adjustment factor for such pro-  
 3 fessional and year. Such additional MIPS  
 4 adjustment factors shall be determined by  
 5 the Secretary in a manner such that pro-  
 6 fessionals having higher composite per-  
 7 formance scores above the additional per-  
 8 formance threshold receive higher addi-  
 9 tional MIPS adjustment factors.

10 “(ii) ADDITIONAL FUNDING POOL.—  
 11 For 2018 and each subsequent year  
 12 through 2023, there is appropriated from  
 13 the Federal Supplementary Medical Insur-  
 14 ance Trust Fund \$500,000,000 for MIPS  
 15 payments under this paragraph resulting  
 16 from the application of the additional  
 17 MIPS adjustment factors under clause (i).

18 “(D) ESTABLISHMENT OF PERFORMANCE  
 19 THRESHOLDS.—

20 “(i) PERFORMANCE THRESHOLD.—  
 21 For each year of the MIPS, the Secretary  
 22 shall compute a performance threshold  
 23 with respect to which the composite per-  
 24 formance score of MIPS eligible profes-  
 25 sionals 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 PERFORMANCE.—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 com-



1           posite performance scores above the  
2           performance threshold with respect to  
3           the prior period described in clause  
4           (i).

5                   “(II) The threshold shall be the  
6           score that is equal to the 25th per-  
7           centile of the actual composite per-  
8           formance scores for MIPS eligible  
9           professionals with composite perform-  
10          ance scores at or above the perform-  
11          ance threshold with respect to the  
12          prior period described in clause (i).

13                   “(iii) SPECIAL RULE FOR INITIAL 2  
14          YEARS.—With respect to each of the first  
15          two years to which the MIPS applies, the  
16          Secretary shall, prior to the performance  
17          period for such years, establish a perform-  
18          ance threshold for purposes of determining  
19          MIPS adjustment factors under subpara-  
20          graph (A) and a threshold for purposes of  
21          determining additional MIPS adjustment  
22          factors under subparagraph (C)(i). Each  
23          such performance threshold shall—

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

1 “(II) take into account—

2 “(aa) data available with re-  
3 spect to performance on meas-  
4 ures and activities that may be  
5 used under the performance cat-  
6 egories under subparagraph  
7 (2)(B); and

8 “(bb) other factors deter-  
9 mined appropriate by the Sec-  
10 retary.

11 “(E) APPLICATION OF MIPS ADJUSTMENT  
12 FACTORS.—In the case of items and services  
13 furnished by a MIPS eligible professional dur-  
14 ing a year (beginning with 2018), the amount  
15 otherwise paid under this part with respect to  
16 such items and services and MIPS eligible pro-  
17 fessional for such year, shall be multiplied by—

18 “(i) 1, plus

19 “(ii) the sum of—

20 “(I) the MIPS adjustment factor  
21 determined under subparagraph (A)  
22 divided by 100, and

23 “(II) as applicable, the additional  
24 MIPS adjustment factor determined

1 under subparagraph (C)(i) divided by  
 2 100.

3 “(F) AGGREGATE APPLICATION OF MIPS  
 4 ADJUSTMENT FACTORS.—

5 “(i) APPLICATION OF SCALING FAC-  
 6 TOR.—

7 “(I) IN GENERAL.—With respect  
 8 to positive MIPS adjustment factors  
 9 under subparagraph (A)(ii)(I) for eli-  
 10 gible professionals whose composite  
 11 performance score is above the per-  
 12 formance threshold under subpara-  
 13 graph (D)(i) for such year, subject to  
 14 subclause (II), the Secretary shall in-  
 15 crease or decrease such adjustment  
 16 factors by a scaling factor in order to  
 17 ensure that the budget neutrality re-  
 18 quirement of clause (ii) is met.

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

22 “(ii) BUDGET NEUTRALITY REQUIRE-  
 23 MENT.—

24 “(I) IN GENERAL.—Subject to  
 25 clause (iii), the Secretary shall ensure

1 that the estimated amount described  
2 in subclause (II) for a year is equal to  
3 the estimated amount described in  
4 subclause (III) for such year.

5 “(II) AGGREGATE INCREASES.—

6 The amount described in this sub-  
7 clause is the estimated increase in the  
8 aggregate allowed charges resulting  
9 from the application of positive MIPS  
10 adjustment factors under subpara-  
11 graph (A) (after application of the  
12 scaling factor described in clause (i))  
13 to MIPS eligible professionals whose  
14 composite performance score for a  
15 year is above the performance thresh-  
16 old under subparagraph (D)(i) for  
17 such year.

18 “(III) AGGREGATE DE-

19 CREASES.—The amount described in  
20 this subclause is the estimated de-  
21 crease in the aggregate allowed  
22 charges resulting from the application  
23 of negative MIPS adjustment factors  
24 under subparagraph (A) to MIPS eli-  
25 gible professionals whose composite

1 performance score for a year is below  
2 the performance threshold under sub-  
3 paragraph (D)(i) for such year.

4 “(iii) EXCEPTIONS.—

5 “(I) In the case that all MIPS el-  
6 igible professionals receive composite  
7 performance scores for a year that are  
8 below the performance threshold  
9 under subparagraph (D)(i) for such  
10 year, the negative MIPS adjustment  
11 factors under subparagraph (A) shall  
12 apply with respect to such MIPS eligi-  
13 ble professionals and the budget neu-  
14 trality requirement of clause (ii) shall  
15 not apply for such year.

16 “(II) In the case that, with re-  
17 spect to a year, the application of  
18 clause (i) results in a scaling factor  
19 equal to the maximum scaling factor  
20 specified in clause (i)(II), such scaling  
21 factor shall apply and the budget neu-  
22 trality requirement of clause (ii) shall  
23 not apply for such year.

24 “(iv) ADDITIONAL INCENTIVE PAY-  
25 MENT ADJUSTMENTS.—In specifying the

1 MIPS additional adjustment factors under  
2 subparagraph (C)(i) for each applicable  
3 MIPS eligible professional for a year, the  
4 Secretary shall ensure that the estimated  
5 increase in payments under this part re-  
6 sulting from the application of such addi-  
7 tional adjustment factors for MIPS eligible  
8 professionals in a year shall be equal (as  
9 estimated by the Secretary) to the addi-  
10 tional funding pool amount for such year  
11 under subparagraph (C)(ii).

12 “(7) ANNOUNCEMENT OF RESULT OF ADJUST-  
13 MENTS.—Under the MIPS, the Secretary shall, not  
14 later than 30 days prior to January 1 of the year  
15 involved, make available to MIPS eligible profes-  
16 sionals the MIPS adjustment factor (and, as appli-  
17 cable, the additional MIPS adjustment factor) under  
18 paragraph (6) applicable to the eligible professional  
19 for items and services furnished by the professional  
20 for such year. The Secretary may include such infor-  
21 mation in the confidential feedback under paragraph  
22 (12).

23 “(8) NO EFFECT IN SUBSEQUENT YEARS.—The  
24 MIPS adjustment factors and additional MIPS ad-  
25 justment factors under paragraph (6) shall apply

1       only with respect to the year involved, and the Sec-  
2       retary shall not take into account such adjustment  
3       factors in making payments to a MIPS eligible pro-  
4       fessional under this part in a subsequent year.

5               “(9) PUBLIC REPORTING.—

6               “(A) IN GENERAL.—The Secretary shall,  
7       in an easily understandable format, make avail-  
8       able on the Physician Compare Internet website  
9       of the Centers for Medicare & Medicaid Serv-  
10      ices the following:

11              “(i) Information regarding the per-  
12      formance of MIPS eligible professionals  
13      under the MIPS, which—

14              “(I) shall include the composite  
15      score for each such MIPS eligible pro-  
16      fessional and the performance of each  
17      such MIPS eligible professional with  
18      respect to each performance category;  
19      and

20              “(II) may include the perform-  
21      ance of each such MIPS eligible pro-  
22      fessional with respect to each measure  
23      or activity specified in paragraph  
24      (2)(B).

1           “(ii) The names of eligible profes-  
2           sionals in eligible alternative payment mod-  
3           els (as defined in section 1833(z)(3)(D))  
4           and, to the extent feasible, the names of  
5           such eligible alternative payment models  
6           and performance of such models.

7           “(B) DISCLOSURE.—The information  
8           made available under this paragraph shall indi-  
9           cate, where appropriate, that publicized infor-  
10          mation may not be representative of the eligible  
11          professional’s entire patient population, the va-  
12          riety of services furnished by the eligible profes-  
13          sional, or the health conditions of individuals  
14          treated.

15          “(C) OPPORTUNITY TO REVIEW AND SUB-  
16          MIT CORRECTIONS.—The Secretary shall pro-  
17          vide for an opportunity for a professional de-  
18          scribed in subparagraph (A) to review, and sub-  
19          mit corrections for, the information to be made  
20          public with respect to the professional under  
21          such subparagraph prior to such information  
22          being made public.

23          “(D) AGGREGATE INFORMATION.—The  
24          Secretary shall periodically post on the Physi-  
25          cian Compare Internet website aggregate infor-



1 mation on the MIPS, including the range of  
2 composite scores for all MIPS eligible profes-  
3 sionals and the range of the performance of all  
4 MIPS eligible professionals with respect to each  
5 performance category.

6 “(10) CONSULTATION.—The Secretary shall  
7 consult with stakeholders in carrying out the MIPS,  
8 including for the identification of measures and ac-  
9 tivities under paragraph (2)(B) and the methodolo-  
10 gies developed under paragraphs (5)(A) and (6) and  
11 regarding the use of qualified clinical data registries.  
12 Such consultation shall include the use of a request  
13 for information or other mechanisms determined ap-  
14 propriate.

15 “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-  
16 TICES AND PRACTICES IN HEALTH PROFESSIONAL  
17 SHORTAGE AREAS.—

18 “(A) IN GENERAL.—The Secretary shall  
19 enter into contracts or agreements with appro-  
20 priate entities (such as quality improvement or-  
21 ganizations, regional extension centers (as de-  
22 scribed in section 3012(c) of the Public Health  
23 Service Act), or regional health collaboratives)  
24 to offer guidance and assistance to MIPS eligi-  
25 ble professionals in practices of 15 or fewer pro-

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.

1                   “(ii) TECHNICAL ASSISTANCE.—Of  
 2                   the amounts transferred pursuant to clause  
 3                   (i) for each of fiscal years 2015 through  
 4                   2019, not less than \$10,000,000 shall be  
 5                   made available for each such year for tech-  
 6                   nical assistance to small practices in health  
 7                   professional shortage areas (as so des-  
 8                   ignated) and medically underserved areas.

9                   “(12) FEEDBACK AND INFORMATION TO IM-  
 10                  PROVE PERFORMANCE.—

11                  “(A) PERFORMANCE FEEDBACK.—

12                   “(i) IN GENERAL.—Beginning July 1,  
 13                   2016, the Secretary—

14                   “(I) shall make available timely  
 15                   (such as quarterly) confidential feed-  
 16                   back to MIPS eligible professionals on  
 17                   the performance of such professionals  
 18                   with respect to the performance cat-  
 19                   egories under clauses (i) and (ii) of  
 20                   paragraph (2)(A); and

21                   “(II) may make available con-  
 22                   fidential feedback to each such profes-  
 23                   sional on the performance of such  
 24                   professional with respect to the per-

1 performance categories under clauses (iii)  
2 and (iv) of such paragraph.

3 “(ii) MECHANISMS.—The Secretary  
4 may use one or more mechanisms to make  
5 feedback available under clause (i), which  
6 may include use of a web-based portal or  
7 other mechanisms determined appropriate  
8 by the Secretary. With respect to the per-  
9 formance category described in paragraph  
10 (2)(A)(i), feedback under this subpara-  
11 graph shall, to the extent an eligible pro-  
12 fessional chooses to participate in a data  
13 registry for purposes of this subsection (in-  
14 cluding registries under subsections (k)  
15 and (m)), be provided based on perform-  
16 ance on quality measures reported through  
17 the use of such registries. With respect to  
18 any other performance category described  
19 in paragraph (2)(A), the Secretary shall  
20 encourage provision of feedback through  
21 qualified clinical data registries as de-  
22 scribed in subsection (m)(3)(E)).

23 “(iii) USE OF DATA.—For purposes of  
24 clause (i), the Secretary may use data,  
25 with respect to a MIPS eligible profes-

1 sional, from periods prior to the current  
2 performance period and may use rolling  
3 periods in order to make illustrative cal-  
4 culations about the performance of such  
5 professional.

6 “(iv) DISCLOSURE EXEMPTION.—  
7 Feedback made available under this sub-  
8 paragraph shall be exempt from disclosure  
9 under section 552 of title 5, United States  
10 Code.

11 “(v) RECEIPT OF INFORMATION.—  
12 The Secretary may use the mechanisms es-  
13 tablished under clause (ii) to receive infor-  
14 mation from professionals, such as infor-  
15 mation with respect to this subsection.

16 “(B) ADDITIONAL INFORMATION.—

17 “(i) IN GENERAL.—Beginning July 1,  
18 2017, the Secretary shall make available to  
19 each MIPS eligible professional informa-  
20 tion, with respect to individuals who are  
21 patients of such MIPS eligible professional,  
22 about items and services for which pay-  
23 ment is made under this title that are fur-  
24 nished to such individuals by other sup-  
25 pliers and providers of services, which may

1 include information described in clause (ii).  
2 Such information may be made available  
3 under the previous sentence to such MIPS  
4 eligible professionals by mechanisms deter-  
5 mined appropriate by the Secretary, which  
6 may include use of a web-based portal.  
7 Such information may be made available in  
8 accordance with the same or similar terms  
9 as data are made available to accountable  
10 care organizations participating in the  
11 shared savings program under section  
12 1899, including a beneficiary opt-out.

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

16 “(I) With respect to selected  
17 items and services (as determined ap-  
18 propriate by the Secretary) for which  
19 payment is made under this title and  
20 that are furnished to individuals, who  
21 are patients of a MIPS eligible profes-  
22 sional, by another supplier or provider  
23 of services during the most recent pe-  
24 riod for which data are available (such  
25 as the most recent three-month pe-

1                   riod), such as the name of such pro-  
2                   viders furnishing such items and serv-  
3                   ices to such patients during such pe-  
4                   riod, the types of such items and serv-  
5                   ices so furnished, and the dates such  
6                   items and services were so furnished.

7                   “(II) Historical data, such as  
8                   averages and other measures of the  
9                   distribution if appropriate, of the  
10                  total, and components of, allowed  
11                  charges (and other figures as deter-  
12                  mined appropriate by the Secretary).

13               “(13) REVIEW.—

14               “(A) TARGETED REVIEW.—The Secretary  
15               shall establish a process under which a MIPS  
16               eligible professional may seek an informal re-  
17               view of the calculation of the MIPS adjustment  
18               factor applicable to such eligible professional  
19               under this subsection for a year. The results of  
20               a review conducted pursuant to the previous  
21               sentence shall not be taken into account for  
22               purposes of paragraph (6) with respect to a  
23               year (other than with respect to the calculation  
24               of such eligible professional’s MIPS adjustment  
25               factor for such year or additional MIPS adjust-

1           ment factor for such year) after the factors de-  
2           termined in subparagraph (A) and subpara-  
3           graph (C) of such paragraph have been deter-  
4           mined for such year.

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

9           “(i) The methodology used to deter-  
10          mine the amount of the MIPS adjustment  
11          factor under paragraph (6)(A) and the  
12          amount of the additional MIPS adjustment  
13          factor under paragraph (6)(C)(i) and the  
14          determination of such amounts.

15          “(ii) The establishment of the per-  
16          formance standards under paragraph (3)  
17          and the performance period under para-  
18          graph (4).

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



1           “(iv) The methodology developed  
2           under paragraph (5) that is used to cal-  
3           culate performance scores and the calcula-  
4           tion of such scores, including the weighting  
5           of measures and activities under such  
6           methodology.”.

7           (2) GAO REPORTS.—

8           (A) EVALUATION OF ELIGIBLE PROFES-  
9           SIONAL MIPS.—Not later than October 1, 2019,  
10          and October 1, 2022, the Comptroller General  
11          of the United States shall submit to Congress  
12          a report evaluating the eligible professional  
13          Merit-based Incentive Payment System under  
14          subsection (q) of section 1848 of the Social Se-  
15          curity Act (42 U.S.C. 1395w-4), as added by  
16          paragraph (1). Such report shall—

17               (i) examine the distribution of the  
18               composite performance scores and MIPS  
19               adjustment factors (and additional MIPS  
20               adjustment factors) for MIPS eligible pro-  
21               fessionals (as defined in subsection  
22               (q)(1)(c) of such section) under such pro-  
23               gram, and patterns relating to such scores  
24               and adjustment factors, including based on

1 type of provider, practice size, geographic  
2 location, and patient mix;

3 (ii) provide recommendations for im-  
4 proving such program;

5 (iii) evaluate the impact of technical  
6 assistance funding under section  
7 1848(q)(11) of the Social Security Act, as  
8 added by paragraph (1), on the ability of  
9 professionals to improve within such pro-  
10 gram or successfully transition to an alter-  
11 native payment model (as defined in sec-  
12 tion 1833(z)(3) of the Social Security Act,  
13 as added by subsection (e)), with priority  
14 for such evaluation given to practices lo-  
15 cated in rural areas, health professional  
16 shortage areas (as designated in section  
17 332(a)(1)(a) of the Public Health Service  
18 Act), and medically underserved areas; and

19 (iv) provide recommendations for opti-  
20 mizing the use of such technical assistance  
21 funds.

22 (B) STUDY TO EXAMINE ALIGNMENT OF  
23 QUALITY MEASURES USED IN PUBLIC AND PRI-  
24 VATE PROGRAMS.—

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

6 (I) compares the similarities and  
7 differences in the use of quality meas-  
8 ures under the original Medicare fee-  
9 for-service program under parts A and  
10 B of title XVIII of the Social Security  
11 Act, the Medicare Advantage program  
12 under part C of such title, selected  
13 State Medicaid programs under title  
14 XIX of such Act, and private payer  
15 arrangements; and

16 (II) makes recommendations on  
17 how to reduce the administrative bur-  
18 den involved in applying such quality  
19 measures.

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

22 (I) consider those measures ap-  
23 plicable to individuals entitled to, or  
24 enrolled for, benefits under such part

1 A, or enrolled under such part B and  
2 individuals under the age of 65; and

3 (II) focus on those measures that  
4 comprise the most significant compo-  
5 nent of the quality performance cat-  
6 egory of the eligible professional  
7 MIPS incentive program under sub-  
8 section (q) of section 1848 of the So-  
9 cial Security Act (42 U.S.C. 1395w-  
10 4), as added by paragraph (1).

11 (C) STUDY ON ROLE OF INDEPENDENT  
12 RISK MANAGERS.—Not later than January 1,  
13 2016, the Comptroller General of the United  
14 States shall submit to Congress a report exam-  
15 ining whether entities that pool financial risk  
16 for physician practices, such as independent  
17 risk managers, can play a role in supporting  
18 physician practices, particularly small physician  
19 practices, in assuming financial risk for the  
20 treatment of patients. Such report shall exam-  
21 ine barriers that small physician practices cur-  
22 rently face in assuming financial risk for treat-  
23 ing patients, the types of risk management enti-  
24 ties that could assist physician practices in par-  
25 ticipating in two-sided risk payment models,

1 and how such entities could assist with risk  
2 management and with quality improvement ac-  
3 tivities. Such report shall also include an anal-  
4 ysis of any existing legal barriers to such ar-  
5 rangements.

6 (D) STUDY TO EXAMINE RURAL AND  
7 HEALTH PROFESSIONAL SHORTAGE AREA AL-  
8 TERNATIVE PAYMENT MODELS.—Not later than  
9 October 1, 2020, and October 1, 2022, the  
10 Comptroller General of the United States shall  
11 submit to Congress a report that examines the  
12 transition of professionals in rural areas, health  
13 professional shortage areas (as designated in  
14 section 332(a)(1)(A) of the Public Health Serv-  
15 ice Act), or medically underserved areas to an  
16 alternative payment model (as defined in sec-  
17 tion 1833(z)(3) of the Social Security Act, as  
18 added by subsection (e)). Such report shall  
19 make recommendations for removing adminis-  
20 trative barriers to practices, including small  
21 practices consisting of 15 or fewer profes-  
22 sionals, in rural areas, health professional  
23 shortage areas, and medically underserved areas  
24 to participation in such models.

1           (3) FUNDING FOR IMPLEMENTATION.—For  
 2           purposes of implementing the provisions of and the  
 3           amendments made by this section, the Secretary of  
 4           Health and Human Services shall provide for the  
 5           transfer of \$80,000,000 from the Supplementary  
 6           Medical Insurance Trust Fund established under  
 7           section 1841 of the Social Security Act (42 U.S.C.  
 8           1395t) to the Centers for Medicare & Medicaid Pro-  
 9           gram Management Account for each of the fiscal  
 10          years 2014 through 2018. Amounts transferred  
 11          under this paragraph shall be available until ex-  
 12          pended.

13          (d) IMPROVING QUALITY REPORTING FOR COM-  
 14          POSITE SCORES.—

15               (1) CHANGES FOR GROUP REPORTING OP-  
 16               TION.—

17                       (A)               IN               GENERAL.—Section  
 18               1848(m)(3)(C)(ii) of the Social Security Act  
 19               (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended  
 20               by inserting “and, for 2015 and subsequent  
 21               years, may provide” after “shall provide”.

22                       (B) CLARIFICATION OF QUALIFIED CLIN-  
 23               ICAL DATA REGISTRY REPORTING TO GROUP  
 24               PRACTICES.—Section 1848(m)(3)(D) of the So-  
 25               cial Security Act (42 U.S.C. 1395w–

1           4(m)(3)(D)) is amended by inserting “and, for  
2           2015 and subsequent years, subparagraph (A)  
3           or (C)” after “subparagraph (A)”.

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

9                   (A) by striking “and subsequent years”  
10                  and inserting “through reporting periods occur-  
11                  ring in 2014”; and

12                  (B) by inserting “and, for reporting peri-  
13                  ods occurring in 2015 and subsequent years,  
14                  the Secretary may establish” following “shall  
15                  establish”.

16           (3) PHYSICIAN FEEDBACK PROGRAM REPORTS  
17           SUCCEEDED BY REPORTS UNDER MIPS.—Section  
18           1848(n) of the Social Security Act (42 U.S.C.  
19           1395w–4(n)) is amended by adding at the end the  
20           following new paragraph:

21                   “(11) REPORTS ENDING WITH 2016.—Reports  
22                  under the Program shall not be provided after De-  
23                  cember 31, 2016. See subsection (q)(12) for reports  
24                  under the eligible professionals Merit-based Incentive  
25                  Payment System.”.

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

8           (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

13          “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

14               “(1) TECHNICAL ADVISORY COMMITTEE.—

15                   “(A) ESTABLISHMENT.—There is estab-  
 16                   lished an ad hoc committee to be known as the  
 17                   ‘Payment Model Technical Advisory Committee’  
 18                   (referred to in this subsection as the ‘Com-  
 19                   mittee’).

20                   “(B) MEMBERSHIP.—

21                       “(i) NUMBER AND APPOINTMENT.—

22                       The Committee shall be composed of 11  
 23                       members appointed by the Comptroller  
 24                       General of the United States.



1           “(ii) QUALIFICATIONS.—The member-  
2           ship of the Committee shall include indi-  
3           viduals with national recognition for their  
4           expertise in payment models and related  
5           delivery of care. No more than 5 members  
6           of the Committee shall be providers of  
7           services or suppliers, or representatives of  
8           providers of services or suppliers.

9           “(iii) PROHIBITION ON FEDERAL EM-  
10          PLOYMENT.—A member of the Committee  
11          shall not be an employee of the Federal  
12          Government.

13          “(iv) ETHICS DISCLOSURE.—The  
14          Comptroller General shall establish a sys-  
15          tem for public disclosure by members of  
16          the Committee of financial and other po-  
17          tential conflicts of interest relating to such  
18          members. Members of the Committee shall  
19          be treated as employees of Congress for  
20          purposes of applying title I of the Ethics  
21          in Government Act of 1978 (Public Law  
22          95–521).

23          “(v) DATE OF INITIAL APPOINT-  
24          MENTS.—The initial appointments of mem-  
25          bers of the Committee shall be made by

1 not later than 180 days after the date of  
2 enactment of this subsection.

3 “(C) TERM; VACANCIES.—

4 “(i) TERM.—The terms of members of  
5 the Committee shall be for 3 years except  
6 that the Comptroller General shall des-  
7 ignate staggered terms for the members  
8 first appointed.

9 “(ii) VACANCIES.—Any member ap-  
10 pointed to fill a vacancy occurring before  
11 the expiration of the term for which the  
12 member’s predecessor was appointed shall  
13 be appointed only for the remainder of that  
14 term. A member may serve after the expi-  
15 ration of that member’s term until a suc-  
16 cessor has taken office. A vacancy in the  
17 Committee shall be filled in the manner in  
18 which the original appointment was made.

19 “(D) DUTIES.—The Committee shall meet,  
20 as needed, to provide comments and rec-  
21 ommendations to the Secretary, as described in  
22 paragraph (2)(C), on physician-focused pay-  
23 ment models.

24 “(E) COMPENSATION OF MEMBERS.—

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

4 “(ii) TRAVEL EXPENSES.—A member  
 5 of the Committee shall be allowed travel  
 6 expenses, including per diem in lieu of sub-  
 7 sistence, at rates authorized for an em-  
 8 ployee of an agency under subchapter I of  
 9 chapter 57 of title 5, United States Code,  
 10 while away from the home or regular place  
 11 of business of the member in the perform-  
 12 ance of the duties of the Committee.

13 “(F) OPERATIONAL AND TECHNICAL SUP-  
 14 PORT.—

15 “(i) IN GENERAL.—The Assistant  
 16 Secretary for Planning and Evaluation  
 17 shall provide technical and operational sup-  
 18 port for the Committee, which may be by  
 19 use of a contractor. The Office of the Ac-  
 20 tuary of the Centers for Medicare & Med-  
 21 icaid Services shall provide to the Com-  
 22 mittee actuarial assistance as needed.

23 “(ii) FUNDING.—The Secretary shall  
 24 provide for the transfer, from the Federal  
 25 Supplementary Medical Insurance Trust

1 Fund under section 1841, such amounts as  
 2 are necessary to carry out clause (i) (not  
 3 to exceed \$5,000,000) for fiscal year 2014  
 4 and each subsequent fiscal year. Any  
 5 amounts transferred under the preceding  
 6 sentence for a fiscal year shall remain  
 7 available until expended.

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

11 “(2) CRITERIA AND PROCESS FOR SUBMISSION  
 12 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT  
 13 MODELS.—

14 “(A) CRITERIA FOR ASSESSING PHYSICIAN-  
 15 FOCUSED PAYMENT MODELS.—

16 “(i) RULEMAKING.—Not later than  
 17 November 1, 2015, the Secretary shall,  
 18 through notice and comment rulemaking,  
 19 following a request for information, estab-  
 20 lish criteria for physician-focused payment  
 21 models, including models for specialist phy-  
 22 sicians, that could be used by the Com-  
 23 mittee for making comments and rec-  
 24 ommendations pursuant to paragraph  
 25 (1)(D).

1                   “(ii) MEDPAC SUBMISSION OF COM-  
2                   MENTS.—During the comment period for  
3                   the proposed rule described in clause (i),  
4                   the Medicare Payment Advisory Commis-  
5                   sion may submit comments to the Sec-  
6                   retary on the proposed criteria under such  
7                   clause.

8                   “(iii) UPDATING.—The Secretary may  
9                   update the criteria established under this  
10                  subparagraph through rulemaking.

11                  “(B) STAKEHOLDER SUBMISSION OF PHY-  
12                  SICIAN FOCUSED PAYMENT MODELS.—On an  
13                  ongoing basis, individuals and stakeholder enti-  
14                  ties may submit to the Committee proposals for  
15                  physician-focused payment models that such in-  
16                  dividuals and entities believe meet the criteria  
17                  described in subparagraph (A).

18                  “(C) TAC REVIEW OF MODELS SUB-  
19                  MITTED.—The Committee shall, on a periodic  
20                  basis, review models submitted under subpara-  
21                  graph (B), prepare comments and recommenda-  
22                  tions regarding whether such models meet the  
23                  criteria described in subparagraph (A), and  
24                  submit such comments and recommendations to  
25                  the Secretary.

1                   “(D) SECRETARY REVIEW AND RE-  
 2                   SPONSE.—The Secretary shall review the com-  
 3                   ments and recommendations submitted by the  
 4                   Committee under subparagraph (C) and post a  
 5                   detailed response to such comments and rec-  
 6                   ommendations on the Internet Website of the  
 7                   Centers for Medicare & Medicaid Services.

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

12                  (2) INCENTIVE PAYMENTS FOR PARTICIPATION  
 13                  IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—  
 14                  Section 1833 of the Social Security Act (42 U.S.C.  
 15                  1395l) is amended by adding at the end the fol-  
 16                  lowing new subsection:

17                  “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN  
 18                  ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

19                         “(1) PAYMENT INCENTIVE.—

20                                 “(A) IN GENERAL.—In the case of covered  
 21                                 professional services furnished by an eligible  
 22                                 professional during a year that is in the period  
 23                                 beginning with 2018 and ending with 2023 and  
 24                                 for which the professional is a qualifying APM  
 25                                 participant, in addition to the amount of pay-

1           ment that would otherwise be made for such  
2           covered professional services under this part for  
3           such year, there also shall be paid to such pro-  
4           fessional an amount equal to 5 percent of the  
5           payment amount for the covered professional  
6           services under this part for the preceding year.  
7           For purposes of the previous sentence, the pay-  
8           ment amount for the preceding year may be an  
9           estimation for the full preceding year based on  
10          a period of such preceding year that is less than  
11          the full year. The Secretary shall establish poli-  
12          cies to implement this subparagraph in cases  
13          where payment for covered professional services  
14          furnished by a qualifying APM participant in  
15          an alternative payment model is made to an en-  
16          tity participating in the alternative payment  
17          model rather than directly to the qualifying  
18          APM participant.

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

22               “(C)   TREATMENT OF PAYMENT INCEN-  
23               TIVE.—Payments under this subsection shall  
24               not be taken into account for purposes of deter-  
25               mining actual expenditures under an alternative

1 payment model and for purposes of determining  
 2 or rebasing any benchmarks used under the al-  
 3 ternative payment model.

4 “(D) COORDINATION.—The amount of the  
 5 additional payment for an item or service under  
 6 this subsection or subsection (m) shall be deter-  
 7 mined without regard to any additional pay-  
 8 ment for the item or service under subsection  
 9 (m) and this subsection, respectively. The  
 10 amount of the additional payment for an item  
 11 or service under this subsection or subsection  
 12 (x) shall be determined without regard to any  
 13 additional payment for the item or service  
 14 under subsection (x) and this subsection, re-  
 15 spectively. The amount of the additional pay-  
 16 ment for an item or service under this sub-  
 17 section or subsection (y) shall be determined  
 18 without regard to any additional payment for  
 19 the item or service under subsection (y) and  
 20 this subsection, respectively.

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

24 “(A) 2018 AND 2019.—With respect to  
 25 2018 and 2019, an eligible professional for



1       whom the Secretary determines that at least 25  
2       percent of payments under this part for covered  
3       professional services furnished by such profes-  
4       sional during the most recent period for which  
5       data are available (which may be less than a  
6       year) were attributable to such services fur-  
7       nished under this part through an entity that  
8       participates in an eligible alternative payment  
9       model with respect to such services.

10       “(B) 2020 AND 2021.—With respect to  
11       2020 and 2021, an eligible professional de-  
12       scribed in either of the following clauses:

13       “(i) MEDICARE REVENUE THRESHOLD  
14       OPTION.—An eligible professional for  
15       whom the Secretary determines that at  
16       least 50 percent of payments under this  
17       part for covered professional services fur-  
18       nished by such professional during the  
19       most recent period for which data are  
20       available (which may be less than a year)  
21       were attributable to such services furnished  
22       under this part through an entity that par-  
23       ticipates in an eligible alternative payment  
24       model with respect to such services.

1 “(ii) COMBINATION ALL-PAYER AND  
2 MEDICARE REVENUE THRESHOLD OP-  
3 TION.—An eligible professional—

4 “(I) for whom the Secretary de-  
5 termines, with respect to items and  
6 services furnished by such professional  
7 during the most recent period for  
8 which data are available (which may  
9 be less than a year), that at least 50  
10 percent of the sum of—

11 “(aa) payments described in  
12 clause (i); and

13 “(bb) all other payments, re-  
14 gardless of payer (other than  
15 payments made by the Secretary  
16 of Defense or the Secretary of  
17 Veterans Affairs under chapter  
18 55 of title 10, United States  
19 Code, or title 38, United States  
20 Code, or any other provision of  
21 law, and other than payments  
22 made under title XIX in a State  
23 in which no medical home or al-  
24 ternative payment model is avail-

1                   able under the State program  
2                   under that title),  
3                   meet the requirement described in  
4                   clause (iii)(I) with respect to pay-  
5                   ments described in item (aa) and meet  
6                   the requirement described in clause  
7                   (iii)(II) with respect to payments de-  
8                   scribed in item (bb);

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

21                  “(III) who provides to the Sec-  
22                  retary such information as is nec-  
23                  essary for the Secretary to make a de-  
24                  termination under subclause (I), with  
25                  respect to such professional.

1 “(iii) REQUIREMENT.—For purposes  
2 of clause (ii)(I)—

3 “(I) the requirement described in  
4 this subclause, with respect to pay-  
5 ments described in item (aa) of such  
6 clause, is that such payments are  
7 made under an eligible alternative  
8 payment model; and

9 “(II) the requirement described  
10 in this subclause, with respect to pay-  
11 ments described in item (bb) of such  
12 clause, is that such payments are  
13 made under an arrangement in  
14 which—

15 “(aa) quality measures com-  
16 parable to measures under the  
17 performance category described  
18 in section 1848(q)(2)(B)(i) apply;

19 “(bb) certified EHR tech-  
20 nology is used; and

21 “(cc) the eligible profes-  
22 sional (AA) bears more than  
23 nominal financial risk if actual  
24 aggregate expenditures exceeds  
25 expected aggregate expenditures;

1 or (BB) is a medical home (with  
2 respect to beneficiaries under  
3 title XIX) that meets criteria  
4 comparable to medical homes ex-  
5 panded under section 1115A(c).

6 “(C) BEGINNING IN 2022.—With respect to  
7 2022 and each subsequent year, an eligible pro-  
8 fessional described in either of the following  
9 clauses:

10 “(i) MEDICARE REVENUE THRESHOLD  
11 OPTION.—An eligible professional for  
12 whom the Secretary determines that at  
13 least 75 percent of payments under this  
14 part for covered professional services fur-  
15 nished by such professional during the  
16 most recent period for which data are  
17 available (which may be less than a year)  
18 were attributable to such services furnished  
19 under this part through an entity that par-  
20 ticipates in an eligible alternative payment  
21 model with respect to such services.

22 “(ii) COMBINATION ALL-PAYER AND  
23 MEDICARE REVENUE THRESHOLD OP-  
24 TION.—An eligible professional—

1 “(I) for whom the Secretary de-  
2 termines, with respect to items and  
3 services furnished by such professional  
4 during the most recent period for  
5 which data are available (which may  
6 be less than a year), that at least 75  
7 percent of the sum of—

8 “(aa) payments described in  
9 clause (i); and

10 “(bb) all other payments, re-  
11 gardless of payer (other than  
12 payments made by the Secretary  
13 of Defense or the Secretary of  
14 Veterans Affairs under chapter  
15 55 of title 10, United States  
16 Code, or title 38, United States  
17 Code, or any other provision of  
18 law, and other than payments  
19 made under title XIX in a State  
20 in which no medical home or al-  
21 ternative payment model is avail-  
22 able under the State program  
23 under that title),  
24 meet the requirement described in  
25 clause (iii)(I) with respect to pay-

1           ments described in item (aa) and meet  
2           the requirement described in clause  
3           (iii)(II) with respect to payments de-  
4           scribed in item (bb);

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

17          “(III) who provides to the Sec-  
18          retary such information as is nec-  
19          essary for the Secretary to make a de-  
20          termination under subclause (I), with  
21          respect to such professional.

22          “(iii) REQUIREMENT.—For purposes  
23          of clause (ii)(I)—

24                 “(I) the requirement described in  
25                 this subclause, with respect to pay-

1           ments described in item (aa) of such  
 2           clause, is that such payments are  
 3           made under an eligible alternative  
 4           payment model; and

5           “(II) the requirement described  
 6           in this subclause, with respect to pay-  
 7           ments described in item (bb) of such  
 8           clause, is that such payments are  
 9           made under an arrangement in  
 10          which—

11           “(aa) quality measures com-  
 12           parable to measures under the  
 13           performance category described  
 14           in section 1848(q)(2)(B)(i) apply;

15           “(bb) certified EHR tech-  
 16           nology is used; and

17           “(cc) the eligible profes-  
 18           sional (AA) bears more than  
 19           nominal financial risk if actual  
 20           aggregate expenditures exceeds  
 21           expected aggregate expenditures;  
 22           or (BB) is a medical home (with  
 23           respect to beneficiaries under  
 24           title XIX) that meets criteria



1 comparable to medical homes ex-  
2 panded under section 1115A(c).

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

5 “(A) COVERED PROFESSIONAL SERV-  
6 ICES.—The term ‘covered professional services’  
7 has the meaning given that term in section  
8 1848(k)(3)(A).

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

12 “(C) ALTERNATIVE PAYMENT MODEL  
13 (APM).—The term ‘alternative payment model’  
14 means any of the following:

15 “(i) A model under section 1115A  
16 (other than a health care innovation  
17 award).

18 “(ii) The shared savings program  
19 under section 1899.

20 “(iii) A demonstration under section  
21 1866C.

22 “(iv) A demonstration required by  
23 Federal law.

24 “(D) ELIGIBLE ALTERNATIVE PAYMENT  
25 MODEL (APM).—

1 “(i) IN GENERAL.—The term ‘eligible  
 2 alternative payment model’ means, with re-  
 3 spect to a year, an alternative payment  
 4 model—

5 “(I) that requires use of certified  
 6 EHR technology (as defined in sub-  
 7 section (o)(4));

8 “(II) that provides for payment  
 9 for covered professional services based  
 10 on quality measures comparable to  
 11 measures under the performance cat-  
 12 egory described in section  
 13 1848(q)(2)(B)(i); and

14 “(III) that satisfies the require-  
 15 ment described in clause (ii).

16 “(ii) ADDITIONAL REQUIREMENT.—  
 17 For purposes of clause (i)(III), the require-  
 18 ment described in this clause, with respect  
 19 to a year and an alternative payment  
 20 model, is that the alternative payment  
 21 model—

22 “(I) is one in which one or more  
 23 entities bear financial risk for mone-  
 24 tary losses under such model that are  
 25 in excess of a nominal amount; or

1 “(II) is a medical home expanded  
2 under section 1115A(c).

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

6 “(A) The determination that an eligible  
7 professional is a qualifying APM participant  
8 under paragraph (2) and the determination  
9 that an alternative payment model is an eligible  
10 alternative payment model under paragraph  
11 (3)(D).

12 “(B) The determination of the amount of  
13 the 5 percent payment incentive under para-  
14 graph (1)(A), including any estimation as part  
15 of such determination.”.

16 (3) COORDINATION CONFORMING AMEND-  
17 MENTS.—Section 1833 of the Social Security Act  
18 (42 U.S.C. 1395l) is further amended—

19 (A) in subsection (x)(3), by adding at the  
20 end the following new sentence: “The amount  
21 of the additional payment for a service under  
22 this subsection and subsection (z) shall be de-  
23 termined without regard to any additional pay-  
24 ment for the service under subsection (z) and  
25 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, hos-

1           pital readmissions rates, and other relevant  
2           and appropriate clinical measures.

3           “(xxiv) Focusing primarily on title  
4           XIX, working in conjunction with the Cen-  
5           ter for Medicaid and CHIP Services.”; and

6           (B) in subparagraph (C)(viii), by striking  
7           “other public sector or private sector payers”  
8           and inserting “other public sector payers, pri-  
9           vate sector payers, or Statewide payment mod-  
10          els”.

11          (5) CONSTRUCTION REGARDING TELEHEALTH  
12          SERVICES.—Nothing in the provisions of, or amend-  
13          ments made by, this Act shall be construed as pre-  
14          cluding an alternative payment model or a qualifying  
15          APM participant (as those terms are defined in sec-  
16          tion 1833(z) of the Social Security Act, as added by  
17          paragraph (1)) from furnishing a telehealth service  
18          for which payment is not made under section  
19          1834(m) of the Social Security Act (42 U.S.C.  
20          1395m(m)).

21          (6) INTEGRATING MEDICARE ADVANTAGE AL-  
22          TERNATIVE PAYMENT MODELS.—Not later than July  
23          1, 2015, the Secretary of Health and Human Serv-  
24          ices shall submit to Congress a study that examines  
25          the feasibility of integrating alternative payment

1 models in the Medicare Advantage payment system.  
 2 The study shall include the feasibility of including a  
 3 value-based modifier and whether such modifier  
 4 should be budget neutral.

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

8 (A) STUDY.—The Secretary of Health and  
 9 Human Services, in consultation with the In-  
 10 spector General of the Department of Health  
 11 and Human Services, shall conduct a study  
 12 that—

13 (i) examines the applicability of the  
 14 Federal fraud prevention laws to items and  
 15 services furnished under title XVIII of the  
 16 Social Security Act for which payment is  
 17 made under an alternative payment model  
 18 (as defined in section 1833(z)(3)(C) of  
 19 such Act (42 U.S.C. 1395l(z)(3)(C)));

20 (ii) identifies aspects of such alter-  
 21 native payment models that are vulnerable  
 22 to fraudulent activity; and

23 (iii) examines the implications of waiv-  
 24 ers to such laws granted in support of such  
 25 alternative payment models, including

1 under any potential expansion of such  
2 models.

3 (B) REPORT.—Not later than 2 years after  
4 the date of the enactment of this Act, the Sec-  
5 retary shall submit to Congress a report con-  
6 taining the results of the study conducted under  
7 subparagraph (A). Such report shall include  
8 recommendations for actions to be taken to re-  
9 duce the vulnerability of such alternative pay-  
10 ment models to fraudulent activity. Such report  
11 also shall include, as appropriate, recommenda-  
12 tions of the Inspector General for changes in  
13 Federal fraud prevention laws to reduce such  
14 vulnerability.

15 (f) IMPROVING PAYMENT ACCURACY.—

16 (1) STUDIES AND REPORTS OF EFFECT OF CER-  
17 TAIN INFORMATION ON QUALITY AND RESOURCE  
18 USE.—

19 (A) STUDY USING EXISTING MEDICARE  
20 DATA.—

21 (i) STUDY.—The Secretary of Health  
22 and Human Services (in this subsection re-  
23 ferred to as the “Secretary”) shall conduct  
24 a study that examines the effect of individ-  
25 uals’ socioeconomic status on quality and

1 resource use outcome measures for individ-  
2 uals under the Medicare program (such as  
3 to recognize that less healthy individuals  
4 may require more intensive interventions).  
5 The study shall use information collected  
6 on such individuals in carrying out such  
7 program, such as urban and rural location,  
8 eligibility for Medicaid (recognizing and ac-  
9 counting for varying Medicaid eligibility  
10 across States), and eligibility for benefits  
11 under the supplemental security income  
12 (SSI) program. The Secretary shall carry  
13 out this paragraph acting through the As-  
14 sistant Secretary for Planning and Evalua-  
15 tion.

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

21 (B) STUDY USING OTHER DATA.—

22 (i) STUDY.—The Secretary shall con-  
23 duct a study that examines the impact of  
24 risk factors, such as those described in sec-  
25 tion 1848(p)(3) of the Social Security Act



1 (42 U.S.C. 1395w-4(p)(3)), race, health  
2 literacy, limited English proficiency (LEP),  
3 and patient activation, on quality and re-  
4 source use outcome measures under the  
5 Medicare program (such as to recognize  
6 that less healthy individuals may require  
7 more intensive interventions). In con-  
8 ducting such study the Secretary may use  
9 existing Federal data and collect such ad-  
10 ditional data as may be necessary to com-  
11 plete the study.

12 (ii) REPORT.—Not later than 5 years  
13 after the date of the enactment of this Act,  
14 the Secretary shall submit to Congress a  
15 report on the study conducted under clause  
16 (i).

17 (C) EXAMINATION OF DATA IN CON-  
18 DUCTING STUDIES.—In conducting the studies  
19 under subparagraphs (A) and (B), the Sec-  
20 retary shall examine what non-Medicare data  
21 sets, such as data from the American Commu-  
22 nity Survey (ACS), can be useful in conducting  
23 the types of studies under such paragraphs and  
24 how such data sets that are identified as useful  
25 can be coordinated with Medicare administra-

1           tive data in order to improve the overall data  
 2           set available to do such studies and for the ad-  
 3           ministration of the Medicare program.

4           (D) RECOMMENDATIONS TO ACCOUNT FOR  
 5           INFORMATION IN PAYMENT ADJUSTMENT  
 6           MECHANISMS.—If the studies conducted under  
 7           subparagraphs (A) and (B) find a relationship  
 8           between the factors examined in the studies and  
 9           quality and resource use outcome measures,  
 10          then the Secretary shall also provide rec-  
 11          ommendations for how the Centers for Medicare  
 12          & Medicaid Services should—

13               (i) obtain access to the necessary data  
 14               (if such data is not already being collected)  
 15               on such factors, including recommenda-  
 16               tions on how to address barriers to the  
 17               Centers in accessing such data; and

18               (ii) account for such factors in deter-  
 19               mining payment adjustments based on  
 20               quality and resource use outcome measures  
 21               under the eligible professional Merit-based  
 22               Incentive Payment System under section  
 23               1848(q) of the Social Security Act (42  
 24               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) HIERARCHICAL 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.

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

3 (i) IN GENERAL.—Taking into ac-  
4 count the studies conducted and rec-  
5 ommendations made in reports under para-  
6 graph (1) and other information as appro-  
7 priate, the Secretary shall, as the Sec-  
8 retary determines appropriate, account for  
9 identified factors with an effect on quality  
10 and resource use outcome measures when  
11 determining payment adjustment mecha-  
12 nisms under provisions of title XVIII of  
13 the Social Security Act that are similar to  
14 the eligible professional Merit-based Incen-  
15 tive Payment System under section  
16 1848(q) of such Act.

17 (ii) ACCESSING DATA.—The Secretary  
18 shall collect or otherwise obtain access to  
19 the data necessary to carry out this para-  
20 graph through existing and new data  
21 sources.

22 (iii) PERIODIC ANALYSES.—The Sec-  
23 retary shall carry out periodic analyses, at  
24 least every 3 years, based on the factors

1                   referred to in clause (i) so as to monitor  
2                   changes in possible relationships.

3                   (C) FUNDING.—There are hereby appro-  
4                   priated from the Federal Supplementary Med-  
5                   ical Insurance Trust Fund under section 1841  
6                   of the Social Security Act to the Secretary to  
7                   carry out this paragraph and the application of  
8                   this paragraph to the Merit-based Incentive  
9                   Payment System under section 1848(q) of such  
10                  Act \$10,000,000, to remain available until ex-  
11                  pended.

12                (3) STRATEGIC PLAN FOR ACCESSING RACE  
13                AND ETHNICITY DATA.—Not later than 18 months  
14                after the date of the enactment of this Act, the Sec-  
15                retary shall develop and report to Congress on a  
16                strategic plan for collecting or otherwise accessing  
17                data on race and ethnicity for purposes of carrying  
18                out the eligible professional Merit-based Incentive  
19                Payment System under section 1848(q) of the Social  
20                Security Act and, as the Secretary determines ap-  
21                propriate, other similar provisions of title XVIII of  
22                such Act.

23                (g) COLLABORATING WITH THE PHYSICIAN, PRACTI-  
24                TIONER, AND OTHER STAKEHOLDER COMMUNITIES TO  
25                IMPROVE RESOURCE USE MEASUREMENT.—Section 1848

1 of the Social Security Act (42 U.S.C. 1395w-4), as  
2 amended by subsection (c), is further amended by adding  
3 at the end the following new subsection:

4 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-  
5 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO  
6 IMPROVE RESOURCE USE MEASUREMENT.—

7 “(1) IN GENERAL.—In order to involve the phy-  
8 sician, practitioner, and other stakeholder commu-  
9 nities in enhancing the infrastructure for resource  
10 use measurement, including for purposes of the  
11 Merit-based Incentive Payment System under sub-  
12 section (q) and alternative payment models under  
13 section 1833(z), the Secretary shall undertake the  
14 steps described in the succeeding provisions of this  
15 subsection.

16 “(2) DEVELOPMENT OF CARE EPISODE AND PA-  
17 TIENT CONDITION GROUPS AND CLASSIFICATION  
18 CODES.—

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

24 “(B) PUBLIC AVAILABILITY OF EXISTING  
25 EFFORTS TO DESIGN AN EPISODE GROUPER.—

1 Not later than 120 days after the date of the  
 2 enactment of this subsection, the Secretary  
 3 shall post on the Internet website of the Cen-  
 4 ters for Medicare & Medicaid Services a list of  
 5 the episode groups developed pursuant to sub-  
 6 section (n)(9)(A) and related descriptive infor-  
 7 mation.

8 “(C) STAKEHOLDER INPUT.—The Sec-  
 9 retary shall accept, through the date that is 60  
 10 days after the day the Secretary posts the list  
 11 pursuant to subparagraph (B), suggestions  
 12 from physician specialty societies, applicable  
 13 practitioner organizations, and other stake-  
 14 holders for episode groups in addition to those  
 15 posted pursuant to such subparagraph, and  
 16 specific clinical criteria and patient characteris-  
 17 tics to classify patients into—

18 “(i) care episode groups; and

19 “(ii) patient condition groups.

20 “(D) DEVELOPMENT OF PROPOSED CLAS-  
 21 SIFICATION CODES.—

22 “(i) IN GENERAL.—Taking into ac-  
 23 count the information described in sub-  
 24 paragraph (B) and the information re-

ceived under subparagraph (C), the Secretary shall—

“(I) establish care episode groups and patient condition groups, which account for a target of an estimated  $\frac{2}{3}$  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



1 groups under clause (i), the Secretary shall  
2 take into account—

3 “(I) the patient’s clinical history  
4 at the time of each medical visit, such  
5 as the patient’s combination of chron-  
6 ic conditions, current health status,  
7 and recent significant history (such as  
8 hospitalization and major surgery dur-  
9 ing a previous period, such as 3  
10 months); and

11 “(II) other factors determined  
12 appropriate by the Secretary, such as  
13 eligibility status under this title (in-  
14 cluding eligibility under section  
15 226(a), 226(b), or 226A, and dual eli-  
16 gibility under this title and title XIX).

17 “(E) DRAFT CARE EPISODE AND PATIENT  
18 CONDITION GROUPS AND CLASSIFICATION  
19 CODES.—Not later than 180 days after the end  
20 of the comment period described in subpara-  
21 graph (C), the Secretary shall post on the  
22 Internet website of the Centers for Medicare &  
23 Medicaid Services a draft list of the care epi-  
24 sode and patient condition codes established

1 under subparagraph (D) (and the criteria and  
2 characteristics assigned to such code).

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

18 “(G) OPERATIONAL LIST OF CARE EPI-  
19 SODE AND PATIENT CONDITION GROUPS AND  
20 CODES.—Not later than 180 days after the end  
21 of the comment period described in subpara-  
22 graph (F), taking into account the comments  
23 received under such subparagraph, the Sec-  
24 retary shall post on the Internet website of the  
25 Centers for Medicare & Medicaid Services an

1 operational list of care episode and patient con-  
2 dition codes (and the criteria and characteris-  
3 tics assigned to such code).

4 “(H) SUBSEQUENT REVISIONS.—Not later  
5 than November 1 of each year (beginning with  
6 2017), the Secretary shall, through rulemaking,  
7 make revisions to the operational lists of care  
8 episode and patient condition codes as the Sec-  
9 retary determines may be appropriate. Such re-  
10 visions may be based on experience, new infor-  
11 mation developed pursuant to subsection  
12 (n)(9)(A), and input from the physician spe-  
13 cialty societies, applicable practitioner organiza-  
14 tions, and other stakeholders, including rep-  
15 resentatives of individuals entitled to benefits  
16 under part A or enrolled under this part.

17 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-  
18 CIANS OR PRACTITIONERS.—

19 “(A) IN GENERAL.—In order to facilitate  
20 the attribution of patients and episodes (in  
21 whole or in part) to one or more physicians or  
22 applicable practitioners furnishing items and  
23 services, the Secretary shall undertake the steps  
24 described in the succeeding provisions of this  
25 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 themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

“(ii) considers themselves 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

1 acute episode of care, but in a supportive  
 2 rather than a lead role;

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

7 “(v) furnishes items and services only  
 8 as ordered by another physician or practi-  
 9 tioner.

10 “(C) DRAFT LIST OF PATIENT RELATION-  
 11 SHIP CATEGORIES AND CODES.—Not later than  
 12 270 days after the date of the enactment of this  
 13 subsection, the Secretary shall post on the  
 14 Internet website of the Centers for Medicare &  
 15 Medicaid Services a draft list of the patient re-  
 16 lationship categories and codes developed under  
 17 subparagraph (B).

18 “(D) STAKEHOLDER INPUT.—The Sec-  
 19 retary shall seek, through the date that is 60  
 20 days after the Secretary posts the list pursuant  
 21 to subparagraph (C), comments from physician  
 22 specialty societies, applicable practitioner orga-  
 23 nizations, and other stakeholders, including rep-  
 24 resentatives of individuals entitled to benefits  
 25 under part A or enrolled under this part, re-

1       garding the patient relationship categories and  
2       codes posted under subparagraph (C). In seek-  
3       ing such comments, the Secretary shall use one  
4       or more mechanisms (other than notice and  
5       comment rulemaking) that may include open  
6       door forums, town hall meetings, or other ap-  
7       propriate mechanisms.

8               “(E) OPERATIONAL LIST OF PATIENT RE-  
9       LATIONSHIP CATEGORIES AND CODES.—Not  
10      later than 180 days after the end of the com-  
11      ment period described in subparagraph (D),  
12      taking into account the comments received  
13      under such subparagraph, the Secretary shall  
14      post on the Internet website of the Centers for  
15      Medicare & Medicaid Services an operational  
16      list of patient relationship categories and codes.

17              “(F) SUBSEQUENT REVISIONS.—Not later  
18      than November 1 of each year (beginning with  
19      2017), the Secretary shall, through rulemaking,  
20      make revisions to the operational list of patient  
21      relationship categories and codes as the Sec-  
22      retary determines appropriate. Such revisions  
23      may be based on experience, new information  
24      developed pursuant to subsection (n)(9)(A), and  
25      input from the physician specialty societies, ap-

1 applicable practitioner organizations, and other  
 2 stakeholders, including representatives of indi-  
 3 viduals entitled to benefits under part A or en-  
 4 rolled under this part.

5 “(4) REPORTING OF INFORMATION FOR RE-  
 6 SOURCE USE MEASUREMENT.—Claims submitted for  
 7 items and services furnished by a physician or appli-  
 8 cable practitioner on or after January 1, 2017, shall,  
 9 as determined appropriate by the Secretary, in-  
 10 clude—

11 “(A) applicable codes established under  
 12 paragraphs (2) and (3); and

13 “(B) the national provider identifier of the  
 14 ordering physician or applicable practitioner (if  
 15 different from the billing physician or applicable  
 16 practitioner).

17 “(5) METHODOLOGY FOR RESOURCE USE ANAL-  
 18 YSIS.—

19 “(A) IN GENERAL.—In order to evaluate  
 20 the resources used to treat patients (with re-  
 21 spect to care episode and patient condition  
 22 groups), the Secretary shall—

23 “(i) use the patient relationship codes  
 24 reported on claims pursuant to paragraph  
 25 (4) to attribute patients (in whole or in

1 part) to one or more physicians and appli-  
2 cable practitioners;

3 “(ii) use the care episode and patient  
4 condition codes reported on claims pursu-  
5 ant to paragraph (4) as a basis to compare  
6 similar patients and care episodes and pa-  
7 tient condition groups; and

8 “(iii) conduct an analysis of resource  
9 use (with respect to care episodes and pa-  
10 tient condition groups of such patients), as  
11 the Secretary determines appropriate.

12 “(B) ANALYSIS OF PATIENTS OF PHYSI-  
13 CIANS AND PRACTITIONERS.—In conducting the  
14 analysis described in subparagraph (A)(iii) with  
15 respect to patients attributed to physicians and  
16 applicable practitioners, the Secretary shall, as  
17 feasible—

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

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

24 “(I) in the case of episodes with-  
25 out a hospitalization, during periods



1 of time (such as the number of days)  
 2 determined appropriate by the Sec-  
 3 retary; and

4 “(II) in the case of episodes with  
 5 a hospitalization, during periods of  
 6 time (such as the number of days) be-  
 7 fore, during, and after the hospitaliza-  
 8 tion.

9 “(C) MEASUREMENT OF RESOURCE USE.—

10 In measuring such resource use, the Sec-  
 11 retary—

12 “(i) shall use per patient total allowed  
 13 charges for all services under part A and  
 14 this part (and, if the Secretary determines  
 15 appropriate, part D) for the analysis of pa-  
 16 tient resource use, by care episode codes  
 17 and by patient condition codes; and

18 “(ii) may, as determined appropriate,  
 19 use other measures of allowed charges  
 20 (such as subtotals for categories of items  
 21 and services) and measures of utilization of  
 22 items and services (such as frequency of  
 23 specific items and services and the ratio of  
 24 specific items and services among attrib-  
 25 uted patients or episodes).

1           “(D) STAKEHOLDER INPUT.—The Sec-  
2           retary shall seek comments from the physician  
3           specialty societies, applicable practitioner orga-  
4           nizations, and other stakeholders, including rep-  
5           resentatives of individuals entitled to benefits  
6           under part A or enrolled under this part, re-  
7           garding the resource use methodology estab-  
8           lished pursuant to this paragraph. In seeking  
9           comments the Secretary shall use one or more  
10          mechanisms (other than notice and comment  
11          rulemaking) that may include open door fo-  
12          rums, town hall meetings, or other appropriate  
13          mechanisms.

14          “(6) IMPLEMENTATION.—To the extent that  
15          the Secretary contracts with an entity to carry out  
16          any part of the provisions of this subsection, the  
17          Secretary may not contract with an entity or an en-  
18          tity with a subcontract if the entity or subcon-  
19          tracting entity currently makes recommendations to  
20          the Secretary on relative values for services under  
21          the fee schedule for physicians’ services under this  
22          section.

23          “(7) LIMITATION.—There shall be no adminis-  
24          trative or judicial review under section 1869, section  
25          1878, or otherwise of—

1           “(A) care episode and patient condition  
2 groups and codes established under paragraph  
3 (2);

4           “(B) patient relationship categories and  
5 codes established under paragraph (3); and

6           “(C) measurement of, and analyses of re-  
7 source use with respect to, care episode and pa-  
8 tient condition codes and patient relationship  
9 codes pursuant to paragraph (5).

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

12           “(9) DEFINITIONS.—In this section:

13           “(A) PHYSICIAN.—The term ‘physician’  
14 has the meaning given such term in section  
15 1861(r)(1).

16           “(B) APPLICABLE PRACTITIONER.—The  
17 term ‘applicable practitioner’ means—

18           “(i) a physician assistant, nurse prac-  
19 titioner, and clinical nurse specialist (as  
20 such terms are defined in section  
21 1861(aa)(5)), and a certified registered  
22 nurse anesthetist (as defined in section  
23 1861(bb)(2)); and

24           “(ii) beginning January 1, 2018, such  
25 other eligible professionals (as defined in

1 subsection (k)(3)(B)) as specified by the  
 2 Secretary.

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

6 **SEC. 102. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**  
 7 **OPMENT.**

8 Section 1848 of the Social Security Act (42 U.S.C.  
 9 1395w-4), as amended by subsections (c) and (g) of sec-  
 10 tion 101, is further amended by inserting at the end the  
 11 following new subsection:

12 “(s) PRIORITIES AND FUNDING FOR MEASURE DE-  
 13 VELOPMENT.—

14 “(1) PLAN IDENTIFYING MEASURE DEVELOP-  
 15 MENT PRIORITIES AND TIMELINES.—

16 “(A) DRAFT MEASURE DEVELOPMENT  
 17 PLAN.—Not later than January 1, 2015, the  
 18 Secretary shall develop, and post on the Inter-  
 19 net website of the Centers for Medicare & Med-  
 20 icaid Services, a draft plan for the development  
 21 of quality measures for application under the  
 22 applicable provisions (as defined in paragraph  
 23 (5)). Under such plan the Secretary shall—

24 “(i) address how measures used by  
 25 private payers and integrated delivery sys-

1           tems could be incorporated under title  
2           XVIII;

3           “(ii) describe how coordination, to the  
4           extent possible, will occur across organiza-  
5           tions developing such measures; and

6           “(iii) take into account how clinical  
7           best practices and clinical practice guide-  
8           lines should be used in the development of  
9           quality measures.

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

13               “(i) Clinical care.

14               “(ii) Safety.

15               “(iii) Care coordination.

16               “(iv) Patient and caregiver experience.

17               “(v) Population health and preven-  
18          tion.

19          “(C) CONSIDERATION.—In developing the  
20          draft plan under this paragraph, the Secretary  
21          shall consider—

22               “(i) gap analyses conducted by the en-  
23               tity with a contract under section 1890(a)  
24               or other contractors or entities;

1 “(ii) whether measures are applicable  
2 across health care settings;

3 “(iii) clinical practice improvement ac-  
4 tivities submitted under subsection  
5 (q)(2)(C)(iv) for identifying possible areas  
6 for future measure development and identi-  
7 fying existing gaps with respect to such  
8 measures; and

9 “(iv) the quality domains applied  
10 under this subsection.

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

14 “(i) Outcome measures, including pa-  
15 tient reported outcome and functional sta-  
16 tus measures.

17 “(ii) Patient experience measures.

18 “(iii) Care coordination measures.

19 “(iv) Measures of appropriate use of  
20 services, including measures of over use.

21 “(E) STAKEHOLDER INPUT.—The Sec-  
22 retary shall accept through March 1, 2015,  
23 comments on the draft plan posted under para-  
24 graph (1)(A) from the public, including health

1 care providers, payers, consumers, and other  
2 stakeholders.

3 “(F) FINAL MEASURE DEVELOPMENT  
4 PLAN.—Not later than May 1, 2015, taking  
5 into account the comments received under this  
6 subparagraph, the Secretary shall finalize the  
7 plan and post on the Internet website of the  
8 Centers for Medicare & Medicaid Services an  
9 operational plan for the development of quality  
10 measures for use under the applicable provi-  
11 sions. Such plan shall be updated as appro-  
12 priate.

13 “(2) CONTRACTS AND OTHER ARRANGEMENTS  
14 FOR QUALITY MEASURE DEVELOPMENT.—

15 “(A) IN GENERAL.—The Secretary shall  
16 enter into contracts or other arrangements with  
17 entities for the purpose of developing, improv-  
18 ing, updating, or expanding in accordance with  
19 the plan under paragraph (1) quality measures  
20 for application under the applicable provisions.  
21 Such entities shall include organizations with  
22 quality measure development expertise.

23 “(B) PRIORITIZATION.—

24 “(i) IN GENERAL.—In entering into  
25 contracts or other arrangements under

1           subparagraph (A), the Secretary shall give  
2           priority to the development of the types of  
3           measures described in paragraph (1)(D).

4           “(ii) CONSIDERATION.—In selecting  
5           measures for development under this sub-  
6           section, the Secretary shall consider—

7                   “(I) whether such measures  
8                   would be electronically specified; and

9                   “(II) clinical practice guidelines  
10                  to the extent that such guidelines  
11                  exist.

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

13               “(A) IN GENERAL.—Not later than May 1,  
14               2016, and annually thereafter, the Secretary  
15               shall post on the Internet website of the Cen-  
16               ters for Medicare & Medicaid Services a report  
17               on the progress made in developing quality  
18               measures for application under the applicable  
19               provisions.

20               “(B) REQUIREMENTS.—Each report sub-  
21               mitted pursuant to subparagraph (A) shall in-  
22               clude the following:

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



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

3 “(I) a description of the total  
 4 number of quality measures developed  
 5 and the types of such measures, such  
 6 as an outcome or patient experience  
 7 measure;

8 “(II) the name of each measure  
 9 developed;

10 “(III) the name of the developer  
 11 and steward of each measure;

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

16 “(V) whether the measure would  
 17 be electronically specified.

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

20 “(I) the information described in  
 21 clause (ii), if available; and

22 “(II) a timeline for completion of  
 23 the development of such measures.

24 “(iv) A description of any updates to  
 25 the plan under paragraph (1) (including

1 newly identified gaps and the status of pre-  
 2 viously identified gaps) and the inventory  
 3 of measures applicable under the applicable  
 4 provisions.

5 “(v) Other information the Secretary  
 6 determines to be appropriate.

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

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

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

16 “(C) other areas related to quality measure  
 17 development determined appropriate by the Sec-  
 18 retary.

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

22 “(A) Subsection (q)(2)(B)(i).

23 “(B) Section 1833(z)(2)(C).

24 “(6) FUNDING.—For purposes of carrying out  
 25 this subsection, the Secretary shall provide for the

1 transfer, from the Federal Supplementary Medical  
 2 Insurance Trust Fund under section 1841, of  
 3 \$15,000,000 to the Centers for Medicare & Medicaid  
 4 Services Program Management Account for each of  
 5 fiscal years 2014 through 2018. Amounts trans-  
 6 ferred under this paragraph shall remain available  
 7 through the end of fiscal year 2021.”.

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

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

13 “(8) ENCOURAGING CARE MANAGEMENT FOR  
 14 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

15 “(A) IN GENERAL.—In order to encourage  
 16 the management of care by an applicable pro-  
 17 vider (as defined in subparagraph (B)) for indi-  
 18 viduals with chronic care needs the Secretary  
 19 shall—

20 “(i) establish one or more HCPCS  
 21 codes for chronic care management serv-  
 22 ices for such individuals; and

23 “(ii) subject to subparagraph (D),  
 24 make payment (as the Secretary deter-  
 25 mines to be appropriate) under this section

1 for such management services furnished on  
 2 or after January 1, 2015, by an applicable  
 3 provider.

4 “(B) APPLICABLE PROVIDER DEFINED.—

5 For purposes of this paragraph, the term ‘ap-  
 6 plicable provider’ means a physician (as defined  
 7 in section 1861(r)(1)), physician assistant or  
 8 nurse practitioner (as defined in section  
 9 1861(aa)(5)(A)), or clinical nurse specialist (as  
 10 defined in section 1861(aa)(5)(B)) who fur-  
 11 nishes services as part of a patient-centered  
 12 medical home or a comparable specialty practice  
 13 that—

14 “(i) is recognized as such a medical  
 15 home or comparable specialty practice by  
 16 an organization that is recognized by the  
 17 Secretary for purposes of such recognition  
 18 as such a medical home or practice; or

19 “(ii) meets such other comparable  
 20 qualifications as the Secretary determines  
 21 to be appropriate.

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

1 “(D) POLICIES RELATING TO PAYMENT.—

2 In carrying out this paragraph, with respect to  
3 chronic care management services, the Sec-  
4 retary shall—

5 “(i) make payment to only one appli-  
6 cable provider for such services furnished  
7 to an individual during a period;

8 “(ii) not make payment under sub-  
9 paragraph (A) if such payment would be  
10 duplicative of payment that is otherwise  
11 made under this title for such services  
12 (such as in the case of hospice care or  
13 home health services); and

14 “(iii) not require that an annual  
15 wellness visit (as defined in section  
16 1861(hhh)) or an initial preventive phys-  
17 ical examination (as defined in section  
18 1861(ww)) be furnished as a condition of  
19 payment for such management services.”.

20 (b) EDUCATION AND OUTREACH.—

21 (1) CAMPAIGN.—

22 (A) IN GENERAL.—The Secretary of  
23 Health and Human Services (in this subsection  
24 referred to as the “Secretary”) shall conduct an  
25 education and outreach campaign to inform

1 professionals who furnish items and services  
2 under part B of title XVIII of the Social Secu-  
3 rity Act and individuals enrolled under such  
4 part of the benefits of chronic care management  
5 services described in section 1848(b)(8) of the  
6 Social Security Act, as added by subsection (a),  
7 and encourage such individuals with chronic  
8 care needs to receive such services.

9 (B) REQUIREMENTS.—Such campaign  
10 shall—

11 (i) be directed by the Office of Rural  
12 Health Policy of the Department of Health  
13 and Human Services and the Office of Mi-  
14 nority Health of the Centers for Medicare  
15 & Medicaid Services; and

16 (ii) focus on encouraging participation  
17 by underserved rural populations and ra-  
18 cial and ethnic minority populations.

19 (2) REPORT.—

20 (A) IN GENERAL.—Not later than Decem-  
21 ber 31, 2017, the Secretary shall submit to  
22 Congress a report on the use of chronic care  
23 management services described in such section  
24 1848(b)(8) by individuals living in rural areas

1 and by racial and ethnic minority populations.

2 Such report shall—

3 (i) identify barriers to receiving chron-

4 ic care management services; and

5 (ii) make recommendations for in-

6 creasing the appropriate use of chronic

7 care management services.

8 **SEC. 104. ENSURING ACCURATE VALUATION OF SERVICES**

9 **UNDER THE PHYSICIAN FEE SCHEDULE.**

10 (a) **AUTHORITY TO COLLECT AND USE INFORMA-**

11 **TION ON PHYSICIANS' SERVICES IN THE DETERMINATION**

12 **OF RELATIVE VALUES.—**

13 (1) **IN GENERAL.—**Section 1848(c)(2) of the

14 Social Security Act (42 U.S.C. 1395w–4(c)(2)) is

15 amended by adding at the end the following new

16 subparagraph:

17 “(M) **AUTHORITY TO COLLECT AND USE**

18 **INFORMATION ON PHYSICIANS' SERVICES IN**

19 **THE DETERMINATION OF RELATIVE VALUES.—**

20 “(i) **COLLECTION OF INFORMATION.—**

21 Notwithstanding any other provision of

22 law, the Secretary may collect or obtain in-

23 formation on the resources directly or indi-

24 rectly related to furnishing services for

25 which payment is made under the fee

1 schedule established under subsection (b).  
2 Such information may be collected or ob-  
3 tained from any eligible professional or any  
4 other source.

5 “(ii) USE OF INFORMATION.—Not-  
6 withstanding any other provision of law,  
7 subject to clause (v), the Secretary may  
8 (as the Secretary determines appropriate)  
9 use information collected or obtained pur-  
10 suant to clause (i) in the determination of  
11 relative values for services under this sec-  
12 tion.

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

17 “(I) Time involved in furnishing  
18 services.

19 “(II) Amounts and types of prac-  
20 tice expense inputs involved with fur-  
21 nishing services.

22 “(III) Prices (net of any dis-  
23 counts) for practice expense inputs,  
24 which may include paid invoice prices  
25 or other documentation or records.



1 “(IV) Overhead and accounting  
 2 information for practices of physicians  
 3 and other suppliers.

4 “(V) Any other element that  
 5 would improve the valuation of serv-  
 6 ices under this section.

7 “(iv) INFORMATION COLLECTION  
 8 MECHANISMS.—Information may be col-  
 9 lected or obtained pursuant to this sub-  
 10 paragraph from any or all of the following:

11 “(I) Surveys of physicians, other  
 12 suppliers, providers of services, manu-  
 13 facturers, and vendors.

14 “(II) Surgical logs, billing sys-  
 15 tems, or other practice or facility  
 16 records.

17 “(III) Electronic health records.

18 “(IV) Any other mechanism de-  
 19 termined appropriate by the Sec-  
 20 retary.

21 “(v) TRANSPARENCY OF USE OF IN-  
 22 FORMATION.—

23 “(I) IN GENERAL.—Subject to  
 24 subclauses (II) and (III), if the Sec-  
 25 retary uses information collected or

1 obtained under this subparagraph in  
2 the determination of relative values  
3 under this subsection, the Secretary  
4 shall disclose the information source  
5 and discuss the use of such informa-  
6 tion in such determination of relative  
7 values through notice and comment  
8 rulemaking.

9 “(II) THRESHOLDS FOR USE.—

10 The Secretary may establish thresh-  
11 olds in order to use such information,  
12 including the exclusion of information  
13 collected or obtained from eligible pro-  
14 fessionals who use very high resources  
15 (as determined by the Secretary) in  
16 furnishing a service.

17 “(III) DISCLOSURE OF INFORMA-

18 TION.—The Secretary shall make ag-  
19 gregate information available under  
20 this subparagraph but shall not dis-  
21 close information in a form or manner  
22 that identifies an eligible professional  
23 or a group practice, or information  
24 collected or obtained pursuant to a  
25 nondisclosure agreement.

1 “(vi) INCENTIVE TO PARTICIPATE.—

2 The Secretary may provide for such pay-  
3 ments under this part to an eligible profes-  
4 sional that submits such solicited informa-  
5 tion under this subparagraph as the Sec-  
6 retary determines appropriate in order to  
7 compensate such eligible professional for  
8 such submission. Such payments shall be  
9 provided in a form and manner specified  
10 by the Secretary.

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

15 “(viii) DEFINITION OF ELIGIBLE PRO-  
16 FESSIOAL.—In this subparagraph, the  
17 term ‘eligible professional’ has the meaning  
18 given such term in subsection (k)(3)(B).

19 “(ix) FUNDING.—For purposes of car-  
20 rying out this subparagraph, in addition to  
21 funds otherwise appropriated, the Sec-  
22 retary shall provide for the transfer, from  
23 the Federal Supplementary Medical Insur-  
24 ance Trust Fund under section 1841, of  
25 \$2,000,000 to the Centers for Medicare &

1 Medicaid Services Program Management  
 2 Account for each fiscal year beginning with  
 3 fiscal year 2014. Amounts transferred  
 4 under the preceding sentence for a fiscal  
 5 year shall be available until expended.”.

6 (2) LIMITATION ON REVIEW.—Section  
 7 1848(i)(1) of the Social Security Act (42 U.S.C.  
 8 1395w-4(i)(1)) is amended—

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

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

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

15 “(F) the collection and use of information  
 16 in the determination of relative values under  
 17 subsection (c)(2)(M).”.

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

24 “(N) AUTHORITY FOR ALTERNATIVE AP-  
 25 PROACHES TO ESTABLISHING PRACTICE EX-

1 PENSE RELATIVE VALUES.—The Secretary may  
 2 establish or adjust practice expense relative val-  
 3 ues under this subsection using cost, charge, or  
 4 other data from suppliers or providers of serv-  
 5 ices, including information collected or obtained  
 6 under subparagraph (M).”.

7 (c) REVISED AND EXPANDED IDENTIFICATION OF  
 8 POTENTIALLY MISVALUED CODES.—Section  
 9 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.  
 10 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

11 “(ii) IDENTIFICATION OF POTEN-  
 12 Tially MISVALUED CODES.—For purposes  
 13 of identifying potentially misvalued codes  
 14 pursuant to clause (i)(I), the Secretary  
 15 shall examine codes (and families of codes  
 16 as appropriate) based on any or all of the  
 17 following criteria:

18 “(I) Codes that have experienced  
 19 the fastest growth.

20 “(II) Codes that have experi-  
 21 enced substantial changes in practice  
 22 expenses.

23 “(III) Codes that describe new  
 24 technologies or services within an ap-  
 25 propriate time period (such as 3

1 years) after the relative values are ini-  
2 tially established for such codes.

3 “(IV) Codes which are multiple  
4 codes that are frequently billed in con-  
5 junction with furnishing a single serv-  
6 ice.

7 “(V) Codes with low relative val-  
8 ues, particularly those that are often  
9 billed multiple times for a single treat-  
10 ment.

11 “(VI) Codes that have not been  
12 subject to review since implementation  
13 of the fee schedule.

14 “(VII) Codes that account for  
15 the majority of spending under the  
16 physician fee schedule.

17 “(VIII) Codes for services that  
18 have experienced a substantial change  
19 in the hospital length of stay or proce-  
20 dure time.

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

24 “(X) Codes for which there is a  
25 significant difference in payment for

1 the same service between different  
2 sites of service.

3 “(XI) Codes for which there may  
4 be anomalies in relative values within  
5 a family of codes.

6 “(XII) Codes for services where  
7 there may be efficiencies when a serv-  
8 ice is furnished at the same time as  
9 other services.

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

12 “(XIV) Codes with high practice  
13 expense relative value units.

14 “(XV) Codes with high cost sup-  
15 plies.

16 “(XVI) Codes as determined ap-  
17 propriate by the Secretary.”

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

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

24 “(O) TARGET FOR RELATIVE VALUE AD-  
25 JUSTMENTS FOR MISVALUED SERVICES.—With

1           respect to fee schedules established for each of  
2           2015 through 2018, the following shall apply:

3                   “(i) DETERMINATION OF NET REDUC-  
4                   TION IN EXPENDITURES.—For each year,  
5                   the Secretary shall determine the esti-  
6                   mated net reduction in expenditures under  
7                   the fee schedule under this section with re-  
8                   spect to the year as a result of adjust-  
9                   ments to the relative values established  
10                  under this paragraph for misvalued codes.

11                  “(ii) BUDGET NEUTRAL REDISTRIBU-  
12                  TION OF FUNDS IF TARGET MET AND  
13                  COUNTING OVERAGES TOWARDS THE TAR-  
14                  GET FOR THE SUCCEEDING YEAR.—If the  
15                  estimated net reduction in expenditures de-  
16                  termined under clause (i) for the year is  
17                  equal to or greater than the target for the  
18                  year—

19                       “(I) reduced expenditures attrib-  
20                       utable to such adjustments shall be  
21                       redistributed for the year in a budget  
22                       neutral manner in accordance with  
23                       subparagraph (B)(ii)(II); and

24                       “(II) the amount by which such  
25                       reduced expenditures exceeds the tar-



1           get for the year shall be treated as a  
 2           reduction in expenditures described in  
 3           clause (i) for the succeeding year, for  
 4           purposes of determining whether the  
 5           target has or has not been met under  
 6           this subparagraph with respect to that  
 7           year.

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

18          “(iv) TARGET RECAPTURE AMOUNT.—  
 19          For purposes of clause (iii), the target re-  
 20          capture amount is, with respect to a year,  
 21          an amount equal to the difference be-  
 22          tween—

23               “(I) the target for the year; and

1 “(II) the estimated net reduction  
 2 in expenditures determined under  
 3 clause (i) for the year.

4 “(v) TARGET.—For purposes of this  
 5 subparagraph, with respect to a year, the  
 6 target is calculated as 0.5 percent of the  
 7 estimated amount of expenditures under  
 8 the fee schedule under this section for the  
 9 year.”.

10 (2) CONFORMING AMENDMENT.—Section  
 11 1848(c)(2)(B)(v) of the Social Security Act (42  
 12 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding  
 13 at the end the following new subclause:

14 “(VIII) REDUCTIONS FOR  
 15 MISVALUED SERVICES IF TARGET NOT  
 16 MET.—Effective for fee schedules be-  
 17 ginning with 2015, reduced expendi-  
 18 tures attributable to the application of  
 19 the target recapture amount described  
 20 in subparagraph (O)(iii).”.

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

23 (1) IN GENERAL.—Section 1848(c) of the So-  
 24 cial Security Act (42 U.S.C. 1395w–4(c)) is amend-

1 ed by adding at the end the following new para-  
 2 graph:

3 “(7) PHASE-IN OF SIGNIFICANT RELATIVE  
 4 VALUE UNIT (RVU) REDUCTIONS.—Effective for fee  
 5 schedules established beginning with 2015, if the  
 6 total relative value units for a service for a year  
 7 would otherwise be decreased by an estimated  
 8 amount equal to or greater than 20 percent as com-  
 9 pared to the total relative value units for the pre-  
 10 vious year, the applicable adjustments in work, prac-  
 11 tice expense, and malpractice relative value units  
 12 shall be phased-in over a 2-year period.”.

13 (2) CONFORMING AMENDMENTS.—Section  
 14 1848(c)(2) of the Social Security Act (42 U.S.C.  
 15 1395w-4(c)(2)) is amended—

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

19 (B) in subparagraph (K)(iii)(VI)—

20 (i) by striking “provisions of subpara-  
 21 graph (B)(ii)(II)” and inserting “provi-  
 22 sions of subparagraph (B)(ii)(II) and para-  
 23 graph (7)”; and

1 (ii) by striking “under subparagraph  
 2 (B)(ii)(II)” and inserting “under subpara-  
 3 graph (B)(ii)(I)”.

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

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

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

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

15 (1) STUDY.—The Comptroller General of the  
 16 United States (in this subsection referred to as the  
 17 “Comptroller General”) shall conduct a study of the  
 18 processes used by the Relative Value Scale Update  
 19 Committee (RUC) to provide recommendations to  
 20 the Secretary of Health and Human Services regard-  
 21 ing relative values for specific services under the  
 22 Medicare physician fee schedule under section 1848  
 23 of the Social Security Act (42 U.S.C. 1395w–4).

24 (2) REPORT.—Not later than 1 year after the  
 25 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report containing  
 2 the results of the study conducted under paragraph  
 3 (1).

4 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-  
 5 ITIES.—

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

10 “(6) USE OF MSAS AS FEE SCHEDULE AREAS IN  
 11 CALIFORNIA.—

12 “(A) IN GENERAL.—Subject to the suc-  
 13 ceeding provisions of this paragraph and not-  
 14 withstanding the previous provisions of this  
 15 subsection, for services furnished on or after  
 16 January 1, 2017, the fee schedule areas used  
 17 for payment under this section applicable to  
 18 California shall be the following:

19 “(i) Each Metropolitan Statistical  
 20 Area (each in this paragraph referred to as  
 21 an ‘MSA’), as defined by the Director of  
 22 the Office of Management and Budget as  
 23 of December 31 of the previous year, shall  
 24 be a fee schedule area.

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

4           “(B) TRANSITION FOR MSAS PREVIOUSLY  
5           IN REST-OF-STATE PAYMENT LOCALITY OR IN  
6           LOCALITY 3.—

7           “(i) IN GENERAL.—For services fur-  
8           nished in California during a year begin-  
9           ning with 2017 and ending with 2021 in  
10          an MSA in a transition area (as defined in  
11          subparagraph (D)), subject to subpara-  
12          graph (C), the geographic index values to  
13          be applied under this subsection for such  
14          year shall be equal to the sum of the fol-  
15          lowing:

16          “(I) CURRENT LAW COMPO-  
17          NENT.—The old weighting factor (de-  
18          scribed in clause (ii)) for such year  
19          multiplied by the geographic index  
20          values under this subsection for the  
21          fee schedule area that included such  
22          MSA that would have applied in such  
23          area (as estimated by the Secretary)  
24          if this paragraph did not apply.

1                   “(II)   MSA-BASED    COMPO-  
 2                   NENT.—The   MSA-based   weighting  
 3                   factor (described in clause (iii)) for  
 4                   such year multiplied by the geographic  
 5                   index values computed for the fee  
 6                   schedule area under subparagraph (A)  
 7                   for the year (determined without re-  
 8                   gard to this subparagraph).

9                   “(ii) OLD WEIGHTING FACTOR.—The  
 10                  old weighting factor described in this  
 11                  clause—

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

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

17                   “(iii) MSA-BASED WEIGHTING FAC-  
 18                  TOR.—The MSA-based weighting factor  
 19                  described in this clause for a year is 1  
 20                  minus the old weighting factor under  
 21                  clause (ii) for that year.

22                   “(C) HOLD HARMLESS.—For services fur-  
 23                  nished in a transition area in California during  
 24                  a year beginning with 2017, the geographic  
 25                  index values to be applied under this subsection

1 for such year shall not be less than the cor-  
 2 responding geographic index values that would  
 3 have applied in such transition area (as esti-  
 4 mated by the Secretary) if this paragraph did  
 5 not apply.

6 “(D) TRANSITION AREA DEFINED.—In  
 7 this paragraph, the term ‘transition area’  
 8 means each of the following fee schedule areas  
 9 for 2013:

10 “(i) The rest-of-State payment local-  
 11 ity.

12 “(ii) Payment locality 3.

13 “(E) REFERENCES TO FEE SCHEDULE  
 14 AREAS.—Effective for services furnished on or  
 15 after January 1, 2017, for California, any ref-  
 16 erence in this section to a fee schedule area  
 17 shall be deemed a reference to a fee schedule  
 18 area established in accordance with this para-  
 19 graph.”.

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



1 (i) DISCLOSURE OF DATA USED TO ESTABLISH  
2 MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—

3 The Secretary of Health and Human Services shall make  
4 publicly available the information used to establish the  
5 multiple procedure payment reduction policy to the profes-  
6 sional component of imaging services in the final rule pub-  
7 lished in the Federal Register, v. 77, n. 222, November  
8 16, 2012, pages 68891–69380 under the physician fee  
9 schedule under section 1848 of the Social Security Act (42  
10 U.S.C. 1395w–4).

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

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

15 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR  
16 CERTAIN IMAGING SERVICES.—

17 “(1) PROGRAM ESTABLISHED.—

18 “(A) IN GENERAL.—The Secretary shall  
19 establish a program to promote the use of ap-  
20 propriate use criteria (as defined in subpara-  
21 graph (B)) for applicable imaging services (as  
22 defined in subparagraph (C)) furnished in an  
23 applicable setting (as defined in subparagraph  
24 (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,

1 specify applicable appropriate use criteria for  
2 applicable imaging services only from among  
3 appropriate use criteria developed or endorsed  
4 by national professional medical specialty soci-  
5 eties or other provider-led entities.

6 “(B) CONSIDERATIONS.—In specifying ap-  
7 plicable appropriate use criteria under subpara-  
8 graph (A), the Secretary shall take into account  
9 whether the criteria—

10 “(i) have stakeholder consensus;

11 “(ii) are scientifically valid and evi-  
12 dence based; and

13 “(iii) are based on studies that are  
14 published and reviewable by stakeholders.

15 “(C) REVISIONS.—The Secretary shall re-  
16 view, on an annual basis, the specified applica-  
17 ble appropriate use criteria to determine if  
18 there is a need to update or revise (as appro-  
19 priate) such specification of applicable appro-  
20 priate use criteria and make such updates or  
21 revisions through rulemaking.

22 “(D) TREATMENT OF MULTIPLE APPLICA-  
23 BLE APPROPRIATE USE CRITERIA.—In the case  
24 where the Secretary determines that more than  
25 one appropriate use criteria applies with respect

1 to an applicable imaging service, the Secretary  
2 shall permit one or more applicable appropriate  
3 use criteria under this paragraph for the serv-  
4 ice.

5 “(3) MECHANISMS FOR CONSULTATION WITH  
6 APPLICABLE APPROPRIATE USE CRITERIA.—

7 “(A) IDENTIFICATION OF MECHANISMS TO  
8 CONSULT WITH APPLICABLE APPROPRIATE USE  
9 CRITERIA.—

10 “(i) IN GENERAL.—The Secretary  
11 shall specify qualified clinical decision sup-  
12 port mechanisms that could be used by or-  
13 dering professionals to consult with appli-  
14 cable appropriate use criteria for applicable  
15 imaging services.

16 “(ii) CONSULTATION.—The Secretary  
17 shall consult with physicians, practitioners,  
18 health care technology experts, and other  
19 stakeholders in specifying mechanisms  
20 under this paragraph.

21 “(iii) INCLUSION OF CERTAIN MECHA-  
22 NISMS.—Mechanisms specified under this  
23 paragraph may include any or all of the  
24 following that meet the requirements de-  
25 scribed in subparagraph (B)(ii):

1 “(I) Use of clinical decision sup-  
2 port modules in certified EHR tech-  
3 nology (as defined in section  
4 1848(o)(4)).

5 “(II) Use of private sector clin-  
6 ical decision support mechanisms that  
7 are independent from certified EHR  
8 technology, which may include use of  
9 clinical decision support mechanisms  
10 available from medical specialty orga-  
11 nizations.

12 “(III) Use of a clinical decision  
13 support mechanism established by the  
14 Secretary.

15 “(B) QUALIFIED CLINICAL DECISION SUP-  
16 PORT MECHANISMS.—

17 “(i) IN GENERAL.—For purposes of  
18 this subsection, a qualified clinical decision  
19 support mechanism is a mechanism that  
20 the Secretary determines meets the re-  
21 quirements described in clause (ii).

22 “(ii) REQUIREMENTS.—The require-  
23 ments described in this clause are the fol-  
24 lowing:

1           “(I) The mechanism makes avail-  
2           able to the ordering professional appli-  
3           cable appropriate use criteria specified  
4           under paragraph (2) and the sup-  
5           porting documentation for the applica-  
6           ble imaging service ordered.

7           “(II) In the case where there are  
8           more than one applicable appropriate  
9           use criteria specified under such para-  
10          graph for an applicable imaging serv-  
11          ice, the mechanism indicates the cri-  
12          teria that it uses for the service.

13          “(III) The mechanism determines  
14          the extent to which an applicable im-  
15          aging service ordered is consistent  
16          with the applicable appropriate use  
17          criteria so specified.

18          “(IV) The mechanism generates  
19          and provides to the ordering profes-  
20          sional a certification or documentation  
21          that documents that the qualified clin-  
22          ical decision support mechanism was  
23          consulted by the ordering professional.

24          “(V) The mechanism is updated  
25          on a timely basis to reflect revisions

1 to the specification of applicable ap-  
2 propriate use criteria under such  
3 paragraph.

4 “(VI) The mechanism meets pri-  
5 vacy and security standards under ap-  
6 plicable provisions of law.

7 “(VII) The mechanism performs  
8 such other functions as specified by  
9 the Secretary, which may include a re-  
10 quirement to provide aggregate feed-  
11 back to the ordering professional.

12 “(C) LIST OF MECHANISMS FOR CON-  
13 SULTATION WITH APPLICABLE APPROPRIATE  
14 USE CRITERIA.—

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

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

24 “(4) CONSULTATION WITH APPLICABLE APPRO-  
25 PRIATE USE CRITERIA.—



1           “(A) CONSULTATION BY ORDERING PRO-  
2           FESSIONAL.—Beginning with January 1, 2017,  
3           subject to subparagraph (C), with respect to an  
4           applicable imaging service ordered by an order-  
5           ing professional that would be furnished in an  
6           applicable setting and paid for under an appli-  
7           cable payment system (as defined in subpara-  
8           graph (D)), an ordering professional shall—

9                   “(i) consult with a qualified decision  
10                  support mechanism listed under paragraph  
11                  (3)(C); and

12                  “(ii) provide to the furnishing profes-  
13                  sional the information described in clauses  
14                  (i) through (iii) of subparagraph (B).

15           “(B) REPORTING BY FURNISHING PROFES-  
16           SIONAL.—Beginning with January 1, 2017,  
17           subject to subparagraph (C), with respect to an  
18           applicable imaging service furnished in an ap-  
19           plicable setting and paid for under an applica-  
20           ble payment system (as defined in subpara-  
21           graph (D)), payment for such service may only  
22           be made if the claim for the service includes the  
23           following:

24                   “(i) Information about which qualified  
25                  clinical decision support mechanism was

1 consulted by the ordering professional for  
2 the service.

3 “(ii) Information regarding—

4 “(I) whether the service ordered  
5 would adhere to the applicable appro-  
6 priate use criteria specified under  
7 paragraph (2);

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

10 “(III) whether such criteria was  
11 not applicable to the service ordered.

12 “(iii) The national provider identifier  
13 of the ordering professional (if different  
14 from the furnishing professional).

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

18 “(i) EMERGENCY SERVICES.—An ap-  
19 plicable imaging service ordered for an in-  
20 dividual with an emergency medical condi-  
21 tion (as defined in section 1867(e)(1)).

22 “(ii) INPATIENT SERVICES.—An appli-  
23 cable imaging service ordered for an inpa-  
24 tient and for which payment is made under  
25 part A.

1 “(iii) ALTERNATIVE PAYMENT MOD-  
 2 ELS.—An applicable imaging service or-  
 3 dered by an ordering professional with re-  
 4 spect to an individual attributed to an al-  
 5 ternative payment model (as defined in  
 6 section 1833(z)(3)(C)).

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

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

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

23 “(ii) The prospective payment system  
 24 for hospital outpatient department services  
 25 under section 1833(t).

1 “(iii) The ambulatory surgical center  
2 payment systems under section 1833(i).

3 “(5) IDENTIFICATION OF OUTLIER ORDERING  
4 PROFESSIONALS.—

5 “(A) IN GENERAL.—With respect to appli-  
6 cable imaging services furnished beginning with  
7 2017, the Secretary shall determine, on an an-  
8 nual basis, no more than five percent of the  
9 total number of ordering professionals who are  
10 outlier ordering professionals.

11 “(B) OUTLIER ORDERING PROFES-  
12 SIONALS.—The determination of an outlier or-  
13 dering professional shall—

14 “(i) be based on low adherence to ap-  
15 plicable appropriate use criteria specified  
16 under paragraph (2), which may be based  
17 on comparison to other ordering profes-  
18 sionals; and

19 “(ii) include data for ordering profes-  
20 sionals for whom prior authorization under  
21 paragraph (6)(A) applies.

22 “(C) USE OF TWO YEARS OF DATA.—The  
23 Secretary shall use two years of data to identify  
24 outlier ordering professionals under this para-  
25 graph.

1           “(D) PROCESS.—The Secretary shall es-  
2           tablish a process for determining when an  
3           outlier ordering professional is no longer an  
4           outlier ordering professional.

5           “(E) CONSULTATION WITH STAKE-  
6           HOLDERS.—The Secretary shall consult with  
7           physicians, practitioners and other stakeholders  
8           in developing methods to identify outlier order-  
9           ing professionals under this paragraph.

10          “(6) PRIOR AUTHORIZATION FOR ORDERING  
11          PROFESSIONALS WHO ARE OUTLIERS.—

12               “(A) IN GENERAL.—Beginning January 1,  
13               2020, subject to paragraph (4)(C), with respect  
14               to services furnished during a year, the Sec-  
15               retary shall, for a period determined appro-  
16               priate by the Secretary, apply prior authoriza-  
17               tion for applicable imaging services that are or-  
18               dered by an outlier ordering professional identi-  
19               fied under paragraph (5).

20               “(B) APPROPRIATE USE CRITERIA IN  
21               PRIOR AUTHORIZATION.—In applying prior au-  
22               thorization under subparagraph (A), the Sec-  
23               retary shall utilize only the applicable appro-  
24               priate use criteria specified under this sub-  
25               section.

1           “(C) FUNDING.—For purposes of carrying  
 2           out this paragraph, the Secretary shall provide  
 3           for the transfer, from the Federal Supple-  
 4           mentary Medical Insurance Trust Fund under  
 5           section 1841, of \$5,000,000 to the Centers for  
 6           Medicare & Medicaid Services Program Man-  
 7           agement Account for each of fiscal years 2019  
 8           through 2021. Amounts transferred under the  
 9           preceding sentence shall remain available until  
 10          expended.

11          “(7) CONSTRUCTION.—Nothing in this sub-  
 12          section shall be construed as granting the Secretary  
 13          the authority to develop or initiate the development  
 14          of clinical practice guidelines or appropriate use cri-  
 15          teria.”.

16          (b)           CONFORMING           AMENDMENT.—Section  
 17          1833(t)(16) of the Social Security Act (42 U.S.C.  
 18          1395l(t)(16)) is amended by adding at the end the fol-  
 19          lowing new subparagraph:

20               “(E) APPLICATION OF APPROPRIATE USE  
 21               CRITERIA FOR CERTAIN IMAGING SERVICES.—  
 22               For provisions relating to the application of ap-  
 23               propriate use criteria for certain imaging serv-  
 24               ices, see section 1834(p).”.

1       (c) REPORT ON EXPERIENCE OF IMAGING APPRO-  
2 PRIATE USE CRITERIA PROGRAM.—Not later than 18  
3 months after the date of the enactment of this Act, the  
4 Comptroller General of the United States shall submit to  
5 Congress a report that includes a description of the extent  
6 to which appropriate use criteria could be used for other  
7 services under part B of title XVIII of the Social Security  
8 Act (42 U.S.C. 1395j et seq.), such as radiation therapy  
9 and clinical diagnostic laboratory services.

10 **SEC. 106. EMPOWERING BENEFICIARY CHOICES THROUGH**  
11 **ACCESS TO INFORMATION ON PHYSICIANS’**  
12 **SERVICES.**

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

16       (b) INFORMATION DESCRIBED.—The following infor-  
17 mation, with respect to an eligible professional, is de-  
18 scribed in this subsection:

19           (1) Information on the number of services fur-  
20 nished by the eligible professional under part B of  
21 title XVIII of the Social Security Act (42 U.S.C.  
22 1395j et seq.), which may include information on the  
23 most frequent services furnished or groupings of  
24 services.

1           (2) Information on submitted charges and pay-  
2           ments for services under such part.

3           (3) A unique identifier for the eligible profes-  
4           sional that is available to the public, such as a na-  
5           tional provider identifier.

6           (c) SEARCHABILITY.—The information made avail-  
7           able under this section shall be searchable by at least the  
8           following:

9           (1) The specialty or type of the eligible profes-  
10          sional.

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

13          (3) The location of the eligible professional.

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

20          (e) IMPLEMENTATION.—

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

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



1 (B) with respect to other eligible profes-  
 2 sionals, by not later than July 1, 2016.

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

7 (f) OPPORTUNITY TO REVIEW AND SUBMIT CORREC-  
 8 TIONS.—The Secretary shall provide for an opportunity  
 9 for an eligible professional to review, and submit correc-  
 10 tions for, the information to be made public with respect  
 11 to the eligible professional under this section prior to such  
 12 information being made public.

13 (g) DEFINITIONS.—In this section:

14 (1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SEC-  
 15 RETARY.—The terms “eligible professional”, “physi-  
 16 cian”, and “Secretary” have the meaning given such  
 17 terms in section 10331(i) of Public Law 111–148.

18 (2) PHYSICIAN COMPARE.—The term “Physi-  
 19 cian Compare” means the Physician Compare Inter-  
 20 net website of the Centers for Medicare & Medicaid  
 21 Services (or a successor website).

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

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

25 (1) ADDITIONAL ANALYSES.—

1 (A) IN GENERAL.—Subject to subpara-  
2 graph (B), to the extent consistent with appli-  
3 cable information, privacy, security, and diselo-  
4 sure laws (including paragraph (3)), notwith-  
5 standing paragraph (4)(B) of section 1874(e) of  
6 the Social Security Act (42 U.S.C. 1395kk(e))  
7 and the second sentence of paragraph (4)(D) of  
8 such section, beginning July 1, 2015, a quali-  
9 fied entity may use the combined data described  
10 in paragraph (4)(B)(iii) of such section received  
11 by such entity under such section, and informa-  
12 tion derived from the evaluation described in  
13 such paragraph (4)(D), to conduct additional  
14 non-public analyses (as determined appropriate  
15 by the Secretary) and provide or sell such anal-  
16 yses to authorized users for non-public use (in-  
17 cluding for the purposes of assisting providers  
18 of services and suppliers to develop and partici-  
19 pate in quality and patient care improvement  
20 activities, including developing new models of  
21 care).

22 (B) LIMITATIONS WITH RESPECT TO ANAL-  
23 YSES.—

24 (i) EMPLOYERS.—Any analyses pro-  
25 vided 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 described 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

1 clauses (i), (ii), and (v) of paragraph  
2 (9)(A) for non-public use, including for the  
3 purposes described in subparagraph (B);  
4 or

5 (ii) subject to subparagraph (C), pro-  
6 vide Medicare claims data to authorized  
7 users described in clauses (i), (ii), and (v),  
8 of paragraph (9)(A) for non-public use, in-  
9 cluding for the purposes described in sub-  
10 paragraph (B).

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

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

21 (3) PROTECTION OF INFORMATION.—

22 (A) IN GENERAL.—Except as provided in  
23 subparagraph (B), an analysis or data that is  
24 provided or sold under paragraph (1) or (2)

1 shall not contain information that individually  
2 identifies a patient.

3 (B) INFORMATION ON PATIENTS OF THE  
4 PROVIDER OF SERVICES OR SUPPLIER.—To the  
5 extent consistent with applicable information,  
6 privacy, security, and disclosure laws, an anal-  
7 ysis or data that is provided or sold to a pro-  
8 vider of services or supplier under paragraph  
9 (1) or (2) may contain information that individ-  
10 ually identifies a patient of such provider or  
11 supplier, including with respect to items and  
12 services furnished to the patient by other pro-  
13 viders of services or suppliers.

14 (C) PROHIBITION ON USING ANALYSES OR  
15 DATA FOR MARKETING PURPOSES.—An author-  
16 ized user shall not use an analysis or data pro-  
17 vided or sold under paragraph (1) or (2) for  
18 marketing purposes.

19 (4) DATA USE AGREEMENT.—A qualified entity  
20 and an authorized user described in clauses (i), (ii),  
21 and (v) of paragraph (9)(A) shall enter into an  
22 agreement regarding the use of any data that the  
23 qualified entity is providing or selling to the author-  
24 ized user under paragraph (2). Such agreement shall  
25 describe the requirements for privacy and security of

1 the data and, as determined appropriate by the Sec-  
 2 retary, any prohibitions on using such data to link  
 3 to other individually identifiable sources of informa-  
 4 tion. If the authorized user is not a covered entity  
 5 under the rules promulgated pursuant to the Health  
 6 Insurance Portability and Accountability Act of  
 7 1996, the agreement shall identify the relevant regu-  
 8 lations, as determined by the Secretary, that the  
 9 user shall comply with as if it were acting in the ca-  
 10 pacity of such a covered entity.

11 (5) NO REDISCLOSURE OF ANALYSES OR  
 12 DATA.—

13 (A) IN GENERAL.—Except as provided in  
 14 subparagraph (B), an authorized user that is  
 15 provided or sold an analysis or data under  
 16 paragraph (1) or (2) shall not redisclose or  
 17 make public such analysis or data or any anal-  
 18 ysis using such data.

19 (B) PERMITTED REDISCLOSURE.—A pro-  
 20 vider of services or supplier that is provided or  
 21 sold an analysis or data under paragraph (1) or  
 22 (2) may, as determined by the Secretary, redis-  
 23 close such analysis or data for the purposes of  
 24 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.

1 (B) ASSESSMENT.—The assessment under  
2 subparagraph (A) shall be an amount up to  
3 \$100 for each individual entitled to, or enrolled  
4 for, benefits under part A of title XVIII of the  
5 Social Security Act or enrolled for benefits  
6 under part B of such title—

7 (i) in the case of an agreement de-  
8 scribed in subparagraph (A)(i), for whom  
9 the Secretary provided data on to the  
10 qualified entity under paragraph (2); and

11 (ii) in the case of an agreement de-  
12 scribed in subparagraph (A)(ii), for whom  
13 the qualified entity provided data on to the  
14 authorized user under paragraph (2).

15 (C) DEPOSIT OF AMOUNTS COLLECTED.—  
16 Any amounts collected pursuant to this para-  
17 graph shall be deposited in Federal Supple-  
18 mentary Medical Insurance Trust Fund under  
19 section 1841 of the Social Security Act (42  
20 U.S.C. 1395t).

21 (8) ANNUAL REPORTS.—Any qualified entity  
22 that provides or sells an analysis or data under  
23 paragraph (1) or (2) shall annually submit to the  
24 Secretary a report that includes—



1 (A) a summary of the analyses provided or  
 2 sold, including the number of such analyses, the  
 3 number of purchasers of such analyses, and the  
 4 total amount of fees received for such analyses;

5 (B) a description of the topics and pur-  
 6 poses of such analyses;

7 (C) information on the entities who re-  
 8 ceived the data under paragraph (2), the uses  
 9 of the data, and the total amount of fees re-  
 10 ceived for providing, selling, or sharing the  
 11 data; and

12 (D) other information determined appro-  
 13 priate by the Secretary.

14 (9) DEFINITIONS.—In this subsection and sub-  
 15 section (b):

16 (A) AUTHORIZED USER.—The term “au-  
 17 thorized user” means the following:

18 (i) A provider of services.

19 (ii) A supplier.

20 (iii) An employer (as defined in sec-  
 21 tion 3(5) of the Employee Retirement In-  
 22 surance Security Act of 1974).

23 (iv) A health insurance issuer (as de-  
 24 fined in section 2791 of the Public Health  
 25 Service Act).

1 (v) A medical society or hospital asso-  
2 ciation.

3 (vi) Any entity not described in  
4 clauses (i) through (v) that is approved by  
5 the Secretary (other than an employer or  
6 health insurance issuer not described in  
7 clauses (iii) and (iv), respectively, as deter-  
8 mined by the Secretary).

9 (B) PROVIDER OF SERVICES.—The term  
10 “provider of services” has the meaning given  
11 such term in section 1861(u) of the Social Se-  
12 curity Act (42 U.S.C. 1395x(u)).

13 (C) QUALIFIED ENTITY.—The term “quali-  
14 fied entity” has the meaning given such term in  
15 section 1874(e)(2) of the Social Security Act  
16 (42 U.S.C. 1395kk(e)).

17 (D) SECRETARY.—The term “Secretary”  
18 means the Secretary of Health and Human  
19 Services.

20 (E) SUPPLIER.—The term “supplier” has  
21 the meaning given such term in section 1861(d)  
22 of the Social Security Act (42 U.S.C.  
23 1395x(d)).

1 (b) ACCESS TO MEDICARE DATA BY QUALIFIED  
2 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY  
3 IMPROVEMENT.—

4 (1) ACCESS.—

5 (A) IN GENERAL.—To the extent con-  
6 sistent with applicable information, privacy, se-  
7 curity, and disclosure laws, beginning July 1,  
8 2015, the Secretary shall, at the request of a  
9 qualified clinical data registry under section  
10 1848(m)(3)(E) of the Social Security Act (42  
11 U.S.C. 1395w–4(m)(3)(E)), provide the data  
12 described in subparagraph (B) (in a form and  
13 manner determined to be appropriate) to such  
14 qualified clinical data registry for purposes of  
15 linking such data with clinical outcomes data  
16 and performing risk-adjusted, scientifically valid  
17 analyses and research to support quality im-  
18 provement or patient safety, provided that any  
19 public reporting of such analyses or research  
20 that identifies a provider of services or supplier  
21 shall only be conducted with the opportunity of  
22 such provider or supplier to appeal and correct  
23 errors in the manner described in subsection  
24 (a)(6).

1 (B) DATA DESCRIBED.—The data de-  
2 scribed in this subparagraph is—

3 (i) claims data under the Medicare  
4 program under title XVIII of the Social  
5 Security Act; and

6 (ii) if the Secretary determines appro-  
7 priate, claims data under the Medicaid  
8 program under title XIX of such Act and  
9 the State Children’s Health Insurance Pro-  
10 gram under title XXI of such Act.

11 (2) FEE.—Data described in paragraph (1)(B)  
12 shall be provided to a qualified clinical data registry  
13 under paragraph (1) at a fee equal to the cost of  
14 providing such data. Any fee collected pursuant to  
15 the preceding sentence shall be deposited in the Cen-  
16 ters for Medicare & Medicaid Services Program  
17 Management Account.

18 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED  
19 ENTITIES.—Section 1874(e) of the Social Security Act  
20 (42 U.S.C. 1395kk(e)) is amended—

21 (1) in the subsection heading, by striking  
22 “MEDICARE”; and

23 (2) in paragraph (3)—

24 (A) by inserting after the first sentence the  
25 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 (1) INDEFINITE, CONTINUING AUTOMATIC EX-  
 2 TENSION OF OPT OUT ELECTION.—

3 (A) IN GENERAL.—Section 1802(b)(3) of  
 4 the Social Security Act (42 U.S.C. 1395a(b)(3))  
 5 is amended—

6 (i) in subparagraph (B)(ii), by strik-  
 7 ing “during the 2-year period beginning on  
 8 the date the affidavit is signed” and insert-  
 9 ing “during the applicable 2-year period  
 10 (as defined in subparagraph (D))”;

11 (ii) in subparagraph (C), by striking  
 12 “during the 2-year period described in sub-  
 13 paragraph (B)(ii)” and inserting “during  
 14 the applicable 2-year period”; and

15 (iii) by adding at the end the fol-  
 16 lowing new subparagraph:

17 “(D) APPLICABLE 2-YEAR PERIODS FOR  
 18 EFFECTIVENESS OF AFFIDAVITS.—In this sub-  
 19 section, the term ‘applicable 2-year period’  
 20 means, with respect to an affidavit of a physi-  
 21 cian or practitioner under subparagraph (B),  
 22 the 2-year period beginning on the date the af-  
 23 fidavit is signed and includes each subsequent  
 24 2-year period unless the physician or practi-  
 25 tioner 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:

1           “(5) POSTING OF INFORMATION ON OPT-OUT  
2       PHYSICIANS AND PRACTITIONERS.—

3           “(A) IN GENERAL.—Beginning not later  
4       than February 1, 2015, the Secretary shall  
5       make publicly available through an appropriate  
6       publicly accessible website of the Department of  
7       Health and Human Services information on the  
8       number and characteristics of opt-out physi-  
9       cians and practitioners and shall update such  
10      information on such website not less often than  
11      annually.

12          “(B) INFORMATION TO BE INCLUDED.—  
13      The information to be made available under  
14      subparagraph (A) shall include at least the fol-  
15      lowing with respect to opt-out physicians and  
16      practitioners:

17           “(i) Their number.

18           “(ii) Their physician or professional  
19      specialty or other designation.

20           “(iii) Their geographic distribution.

21           “(iv) The timing of their becoming  
22      opt-out physicians and practitioners, rel-  
23      ative to when they first entered practice  
24      and with respect to applicable 2-year peri-  
25      ods.



1                   “(v) The proportion of such physi-  
2                   cians and practitioners who billed for  
3                   emergency or urgent care services.”.

4           (b) GAINSHARING STUDY AND REPORT.—Not later  
5 than 6 months after the date of the enactment of this Act,  
6 the Secretary of Health and Human Services, in consulta-  
7 tion with the Inspector General of the Department of  
8 Health and Human Services, shall submit to Congress a  
9 report with legislative recommendations to amend existing  
10 fraud and abuse laws, through exceptions, safe harbors,  
11 or other narrowly targeted provisions, to permit  
12 gainsharing or similar arrangements between physicians  
13 and hospitals that improve care while reducing waste and  
14 increasing efficiency. The report shall—

15           (1) consider whether such provisions should  
16           apply to ownership interests, compensation arrange-  
17           ments, or other relationships;

18           (2) describe how the recommendations address  
19           accountability, transparency, and quality, including  
20           how best to limit inducements to stint on care, dis-  
21           charge patients prematurely, or otherwise reduce or  
22           limit medically necessary care; and

23           (3) consider whether a portion of any savings  
24           generated by such arrangements should accrue to

1 the Medicare program under title XVIII of the So-  
2 cial Security Act.

3 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC  
4 HEALTH RECORD SYSTEMS.—

5 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-  
6 SPREAD EHR INTEROPERABILITY.—

7 (A) OBJECTIVE.—As a consequence of a  
8 significant Federal investment in the implemen-  
9 tation of health information technology through  
10 the Medicare and Medicaid EHR incentive pro-  
11 grams, Congress declares it a national objective  
12 to achieve widespread exchange of health infor-  
13 mation through interoperable certified EHR  
14 technology nationwide by December 31, 2017.

15 (B) DEFINITIONS.—In this paragraph:

16 (i) WIDESPREAD INTEROPER-  
17 ABILITY.—The term “widespread inter-  
18 operability” means interoperability between  
19 certified EHR technology systems em-  
20 ployed by meaningful EHR users under  
21 the Medicare and Medicaid EHR incentive  
22 programs and other clinicians and health  
23 care providers on a nationwide basis.

24 (ii) INTEROPERABILITY.—The term  
25 “interoperability” means the ability of two

1 or more health information systems or  
2 components to exchange clinical and other  
3 information and to use the information  
4 that has been exchanged using common  
5 standards as to provide access to longitu-  
6 dinal information for health care providers  
7 in order to facilitate coordinated care and  
8 improved patient outcomes.

9 (C) ESTABLISHMENT OF METRICS.—Not  
10 later than July 1, 2015, and in consultation  
11 with stakeholders, the Secretary shall establish  
12 metrics to be used to determine if and to the  
13 extent that the objective described in subpara-  
14 graph (A) has been achieved.

15 (D) RECOMMENDATIONS IF OBJECTIVE  
16 NOT ACHIEVED.—If the Secretary of Health  
17 and Human Services determines that the objec-  
18 tive described in subparagraph (A) has not been  
19 achieved by December 31, 2017, then the Sec-  
20 retary shall submit to Congress a report, by not  
21 later than December 31, 2018, that identifies  
22 barriers to such objective and recommends ac-  
23 tions that the Federal Government can take to  
24 achieve such objective. Such recommended ac-  
25 tions 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 hos-

1           pital has not knowingly and willfully taken any  
2           action to limit or restrict the compatibility or  
3           interoperability of the certified EHR tech-  
4           nology”.

5           (C) EFFECTIVE DATE.—The amendments  
6           made by this subsection shall apply to meaning-  
7           ful EHR users as of the date that is one year  
8           after the date of the enactment of this Act.

9           (3) STUDY AND REPORT ON THE FEASIBILITY  
10          OF ESTABLISHING A WEBSITE TO COMPARE CER-  
11          TIFIED EHR TECHNOLOGY PRODUCTS.—

12          (A) STUDY.—The Secretary shall conduct  
13          a study to examine the feasibility of estab-  
14          lishing mechanisms that includes aggregated re-  
15          sults of surveys of meaningful EHR users on  
16          the functionality of certified EHR technology  
17          products to enable such users to directly com-  
18          pare the functionality and other features of  
19          such products. Such information may be made  
20          available through contracts with physician, hos-  
21          pital, or other organizations that maintain such  
22          comparative information.

23          (B) REPORT.—Not later than 1 year after  
24          the date of the enactment of this Act, the Sec-  
25          retary shall submit to Congress a report on the

1 website. The report shall include information on  
2 the benefits of, and resources needed to develop  
3 and maintain, such a website.

4 (4) DEFINITIONS.—In this subsection:

5 (A) The term “certified EHR technology”  
6 has the meaning given such term in section  
7 1848(o)(4) of the Social Security Act (42  
8 U.S.C. 1395w–4(o)(4)).

9 (B) The term “meaningful EHR user” has  
10 the meaning given such term under the Medi-  
11 care EHR incentive programs.

12 (C) The term “Medicare and Medicaid  
13 EHR incentive programs” means—

14 (i) in the case of the Medicare pro-  
15 gram under title XVIII of the Social Secu-  
16 rity Act, the incentive programs under sec-  
17 tion 1814(l)(3), section 1848(o), sub-  
18 sections (l) and (m) of section 1853, and  
19 section 1886(n) of the Social Security Act  
20 (42 U.S.C. 1395f(l)(3), 1395w–4(o),  
21 1395w–23, 1395ww(n)); and

22 (ii) in the case of the Medicaid pro-  
23 gram under title XIX of such Act, the in-  
24 centive program under subsections

1 (a)(3)(F) and (t) of section 1903 of such  
2 Act (42 U.S.C. 1396b).

3 (D) The term “Secretary” means the Sec-  
4 retary of Health and Human Services.

5 (d) GAO STUDIES AND REPORTS ON THE USE OF  
6 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-  
7 MOTE PATIENT MONITORING SERVICES.—

8 (1) STUDY ON TELEHEALTH SERVICES.—The  
9 Comptroller General of the United States shall con-  
10 duct a study on the following:

11 (A) How the definition of telehealth across  
12 various Federal programs and Federal efforts  
13 can inform the use of telehealth in the Medicare  
14 program under title XVIII of the Social Secu-  
15 rity Act (42 U.S.C. 1395 et seq.).

16 (B) Issues that can facilitate or inhibit the  
17 use of telehealth under the Medicare program  
18 under such title, including oversight and profes-  
19 sional licensure, changing technology, privacy  
20 and security, infrastructure requirements, and  
21 varying needs across urban and rural areas.

22 (C) Potential implications of greater use of  
23 telehealth with respect to payment and delivery  
24 system transformations under the Medicare  
25 program under such title XVIII and the Med-

1           icaid program under title XIX of such Act (42  
2           U.S.C. 1396 et seq.).

3           (D) How the Centers for Medicare & Med-  
4           icaid Services conducts oversight of payments  
5           made under the Medicare program under such  
6           title XVIII to providers for telehealth services.

7           (2) STUDY ON REMOTE PATIENT MONITORING  
8           SERVICES.—

9           (A) IN GENERAL.—The Comptroller Gen-  
10          eral of the United States shall conduct a  
11          study—

12               (i) of the dissemination of remote pa-  
13               tient monitoring technology in the private  
14               health insurance market;

15               (ii) of the financial incentives in the  
16               private health insurance market relating to  
17               adoption of such technology;

18               (iii) of the barriers to adoption of  
19               such services under the Medicare program  
20               under title XVIII of the Social Security  
21               Act;

22               (iv) that evaluates the patients, condi-  
23               tions, and clinical circumstances that could  
24               most benefit from remote patient moni-  
25               toring services; and



1 (v) that evaluates the challenges re-  
2 lated to establishing appropriate valuation  
3 for remote patient monitoring services  
4 under the Medicare physician fee schedule  
5 under section 1848 of the Social Security  
6 Act (42 U.S.C. 1395w-4) in order to accu-  
7 rately reflect the resources involved in fur-  
8 nishing such services.

9 (B) DEFINITIONS.—For purposes of this  
10 paragraph:

11 (i) REMOTE PATIENT MONITORING  
12 SERVICES.—The term “remote patient  
13 monitoring services” means services fur-  
14 nished through remote patient monitoring  
15 technology.

16 (ii) REMOTE PATIENT MONITORING  
17 TECHNOLOGY.—The term “remote patient  
18 monitoring technology” means a coordi-  
19 nated system that uses one or more home-  
20 based or mobile monitoring devices that  
21 automatically transmit vital sign data or  
22 information on activities of daily living and  
23 may include responses to assessment ques-  
24 tions collected on the devices wirelessly or  
25 through a telecommunications connection

1 to a server that complies with the Federal  
2 regulations (concerning the privacy of indi-  
3 vidually identifiable health information)  
4 promulgated under section 264(c) of the  
5 Health Insurance Portability and Account-  
6 ability Act of 1996, as part of an estab-  
7 lished plan of care for that patient that in-  
8 cludes the review and interpretation of that  
9 data by a health care professional.

10 (3) REPORTS.—Not later than 24 months after  
11 the date of the enactment of this Act, the Comp-  
12 troller General shall submit to Congress—

13 (A) a report containing the results of the  
14 study conducted under paragraph (1); and

15 (B) a report containing the results of the  
16 study conducted under paragraph (2).

17 A report required under this paragraph shall be sub-  
18 mitted together with recommendations for such leg-  
19 islation and administrative action as the Comptroller  
20 General determines appropriate. The Comptroller  
21 General may submit one report containing the re-  
22 sults described in subparagraphs (A) and (B) and  
23 the recommendations described in the previous sen-  
24 tence.

1       (e)     RULE     OF     CONSTRUCTION     REGARDING  
2 HEALTHCARE PROVIDER STANDARDS OF CARE.—

3             (1) MAINTENANCE OF STATE STANDARDS.—

4       The development, recognition, or implementation of  
5 any guideline or other standard under any Federal  
6 health care provision shall not be construed—

7             (A) to establish the standard of care or  
8 duty of care owed by a health care provider to  
9 a patient in any medical malpractice or medical  
10 product liability action or claim; or

11            (B) to preempt any standard of care or  
12 duty of care, owed by a health care provider to  
13 a patient, duly established under State or com-  
14 mon law.

15            (2) DEFINITIONS.—For purposes of this sub-  
16 section:

17             (A) FEDERAL HEALTH CARE PROVISION.—

18       The term “Federal health care provision”  
19 means any provision of the Patient Protection  
20 and Affordable Care Act (Public Law 111–  
21 148), title I or subtitle B of title II of the  
22 Health Care and Education Reconciliation Act  
23 of 2010 (Public Law 111–152), or title XVIII  
24 or XIX of the Social Security Act.

1 (B) HEALTH CARE PROVIDER.—The term  
2 “health care provider” means any individual or  
3 entity—

4 (i) licensed, registered, or certified  
5 under Federal or State laws or regulations  
6 to provide health care services; or

7 (ii) required to be so licensed, reg-  
8 istered, or certified but that is exempted  
9 by other statute or regulation.

10 (C) MEDICAL MALPRACTICE OR MEDICAL  
11 PRODUCT LIABILITY ACTION OR CLAIM.—The  
12 term “medical malpractice or medical product  
13 liability action or claim” means a medical mal-  
14 practice action or claim (as defined in section  
15 431(7) of the Health Care Quality Improve-  
16 ment Act of 1986 (42 U.S.C. 11151(7))) and  
17 includes a liability action or claim relating to a  
18 health care provider’s prescription or provision  
19 of a drug, device, or biological product (as such  
20 terms are defined in section 201 of the Federal  
21 Food, Drug, and Cosmetic Act or section 351  
22 of the Public Health Service Act).

23 (D) STATE.—The term “State” includes  
24 the District of Columbia, Puerto Rico, and any

1           other commonwealth, possession, or territory of  
2           the United States.

3           (3) PRESERVATION OF STATE LAW.—No provi-  
4           sion of the Patient Protection and Affordable Care  
5           Act (Public Law 111–148), title I or subtitle B of  
6           title II of the Health Care and Education Reconcili-  
7           ation Act of 2010 (Public Law 111–152), or title  
8           XVIII or XIX of the Social Security Act shall be  
9           construed to preempt any State or common law gov-  
10          erning medical professional or medical product liabil-  
11          ity actions or claims.

## 12           **TITLE II—EXTENSIONS**

### 13          **Subtitle A—Medicare Extensions**

#### 14          **SEC. 201. WORK GEOGRAPHIC ADJUSTMENT.**

15          Section 1848(e)(1)(E) of the Social Security Act (42  
16          U.S.C. 1395w–4(e)(1)(E)) is amended by striking “and  
17          before April 1, 2014,”.

#### 18          **SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES.**

19          (a) REPEAL OF THERAPY CAP AND 1-YEAR EXTEN-  
20          SION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—  
21          Section 1833(g) of the Social Security Act (42 U.S.C.  
22          1395l(g)) is amended—  
23          (1) in paragraph (4)—

1 (A) by striking “This subsection” and in-  
 2 serting “Except as provided in paragraph  
 3 (5)(C)(iii), this subsection”; and

4 (B) by inserting the following before the  
 5 period at the end: “or with respect to services  
 6 furnished on or after the date of enactment of  
 7 the Responsible Medicare SGR Repeal and Ben-  
 8 eficiary Access Improvement Act of 2014”; and  
 9 (2) in paragraph (5)(C), by adding at the end  
 10 the following new clause:

11 “(iii) Beginning on the date of enactment of the Re-  
 12 sponsible Medicare SGR Repeal and Beneficiary Access  
 13 Improvement Act of 2014 and ending on the day before  
 14 the date that is 12 months after such date of enactment,  
 15 the manual medical review process described in clause (i)  
 16 shall apply with respect to expenses incurred in a year for  
 17 services described in paragraphs (1) and (3) that exceed  
 18 the threshold described in clause (ii) for the year.”.

19 (b) MEDICAL REVIEW OF OUTPATIENT THERAPY  
 20 SERVICES.—

21 (1) MEDICAL REVIEW OF OUTPATIENT THER-  
 22 APY SERVICES.—Section 1833 of the Social Security  
 23 Act (42 U.S.C. 1395l), as amended by section  
 24 101(e)(2), is amended by adding at the end the fol-  
 25 lowing new subsection:

1       “(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY  
2 SERVICES.—

3               “(1) IN GENERAL.—

4                       “(A) PROCESS FOR MEDICAL REVIEW.—

5           The Secretary shall implement a process for the  
6           medical review (as described in paragraph (2))  
7           of outpatient therapy services (as defined in  
8           paragraph (10)) and, subject to paragraph  
9           (12), apply such process to such services fur-  
10          nished on or after the date that is 12 months  
11          after the date of enactment of the Responsible  
12          Medicare SGR Repeal and Beneficiary Access  
13          Improvement Act of 2014, focusing on services  
14          identified under subparagraph (B).

15               “(B) IDENTIFICATION OF SERVICES FOR  
16          REVIEW.—Under the process, the Secretary  
17          shall identify services for medical review, using  
18          such factors as the Secretary determines appro-  
19          priate, which may include the following:

20                       “(i) Services furnished by a therapy  
21                       provider (as defined in paragraph (10))  
22                       whose pattern of billing is aberrant com-  
23                       pared to peers.

24                       “(ii) Services furnished by a therapy  
25                       provider who, in a prior period, has a high

1 claims denial percentage or is less compli-  
2 ant with other applicable requirements  
3 under this title.

4 “(iii) Services furnished by a therapy  
5 provider that is newly enrolled under this  
6 title.

7 “(iv) Services furnished by a therapy  
8 provider who has questionable billing prac-  
9 tices, such as billing medically unlikely  
10 units of services in a day.

11 “(v) Services furnished to treat a type  
12 of medical condition.

13 “(vi) Services identified by use of the  
14 standardized data elements required to be  
15 reported under section 1834(p).

16 “(vii) Services furnished by a single  
17 therapy provider or a group that includes  
18 a therapy provider identified by factors de-  
19 scribed in this subparagraph.

20 “(viii) Other services as determined  
21 appropriate by the Secretary.

22 “(2) MEDICAL REVIEW.—

23 “(A) PRIOR AUTHORIZATION MEDICAL RE-  
24 VIEW.—



1           “(i) IN GENERAL.—Subject to the  
2           succeeding provisions of this subparagraph,  
3           the Secretary shall use prior authorization  
4           medical review for outpatient therapy serv-  
5           ices furnished to an individual above one  
6           or more thresholds established by the Sec-  
7           retary, such as a dollar threshold or a  
8           threshold based on other factors.

9           “(ii) ENDING APPLICATION OF PRIOR  
10          AUTHORIZATION FOR A THERAPY PRO-  
11          VIDER.—The Secretary shall end the appli-  
12          cation of prior authorization medical re-  
13          view to outpatient therapy services fur-  
14          nished by a therapy provider if the Sec-  
15          retary determines that the provider has a  
16          low denial rate under such prior authoriza-  
17          tion. The Secretary may subsequently re-  
18          apply prior authorization medical review to  
19          such therapy provider if the Secretary de-  
20          termines it to be appropriate.

21          “(iii) PRIOR AUTHORIZATION OF MUL-  
22          TIPLE SERVICES.—The Secretary shall,  
23          where practicable, provide for prior author-  
24          ization medical review for multiple services  
25          at a single time, such as services in a ther-

1           apy plan of care described in section  
2           1861(p)(2).

3           “(B) OTHER TYPES OF MEDICAL RE-  
4           VIEW.—The Secretary may use pre-payment re-  
5           view or post-payment review for services identi-  
6           fied under paragraph (1)(B) that are not sub-  
7           ject to prior authorization medical review under  
8           subparagraph (A).

9           “(C) LIMITATION FOR LAW ENFORCEMENT  
10          ACTIVITIES.—The Secretary may determine  
11          that medical review under this subsection does  
12          not apply in the case where potential fraud may  
13          be involved.

14          “(3) REVIEW CONTRACTORS.—The Secretary  
15          shall conduct prior authorization medical review of  
16          outpatient therapy services under this subsection  
17          using medicare administrative contractors (as de-  
18          scribed in section 1874A) or other review contrac-  
19          tors (other than contractors under section 1893(h)  
20          or contractors paid on a contingent basis).

21          “(4) NO PAYMENT WITHOUT PRIOR AUTHORIZA-  
22          TION.—With respect to an outpatient therapy service  
23          for which prior authorization medical review under  
24          this subsection applies, the following shall apply:

1           “(A) PRIOR AUTHORIZATION DETERMINA-  
2           TION.—The Secretary shall make a determina-  
3           tion, prior to the service being furnished, of  
4           whether the service would or would not meet  
5           the applicable requirements of section  
6           1862(a)(1)(A).

7           “(B) DENIAL OF PAYMENT.—Subject to  
8           paragraph (6), no payment shall be made under  
9           this part for the service unless the Secretary  
10          determines pursuant to subparagraph (A) that  
11          the service would meet the applicable require-  
12          ments of such section.

13          “(5) SUBMISSION OF INFORMATION.—A ther-  
14          apy provider may submit the information necessary  
15          for medical review by fax, by mail, or by electronic  
16          means. The Secretary shall make available the elec-  
17          tronic means described in the preceding sentence as  
18          soon as practicable, but not later than 24 months  
19          after the date of enactment of this subsection.

20          “(6) TIMELINESS.—If the Secretary does not  
21          make a prior authorization determination under  
22          paragraph (4)(A) within 10 business days of the  
23          date of the Secretary’s receipt of medical docu-  
24          mentation needed to make such determination, para-  
25          graph (4)(B) shall not apply.

1           “(7) CONSTRUCTION.—With respect to an out-  
2       patient therapy service that has been affirmed by  
3       medical review under this subsection, nothing in this  
4       subsection shall be construed to preclude the subse-  
5       quent denial of a claim for such service that does  
6       not meet other applicable requirements under this  
7       Act.

8           “(8) BENEFICIARY PROTECTIONS.—With re-  
9       spect to services furnished on or after January 1,  
10      2015, where payment may not be made as a result  
11      of application of medical review under this sub-  
12      section, section 1879 shall apply in the same manner  
13      as such section applies to a denial that is made by  
14      reason of section 1862(a)(1).

15          “(9) IMPLEMENTATION.—

16               “(A) AUTHORITY.—The Secretary may im-  
17       plement the provisions of this subsection by in-  
18       terim final rule with comment period.

19               “(B) ADMINISTRATION.—Chapter 35 of  
20       title 44, United States Code, shall not apply to  
21       medical review under this subsection.

22               “(C) LIMITATION.—There shall be no ad-  
23       ministrative or judicial review under section  
24       1869, section 1878, or otherwise of the identi-  
25       fication of services for medical review or the

1 process for medical review under this sub-  
2 section.

3 “(10) DEFINITIONS.—For purposes of this sub-  
4 section:

5 “(A) OUTPATIENT THERAPY SERVICES.—

6 The term ‘outpatient therapy services’ means  
7 the following services for which payment is  
8 made under section 1848, 1834(g), or 1834(k):

9 “(i) Physical therapy services of the  
10 type described in section 1861(p).

11 “(ii) Speech-language pathology serv-  
12 ices of the type described in such section  
13 though the application of section  
14 1861(ll)(2).

15 “(iii) Occupational therapy services of  
16 the type described in section 1861(p)  
17 through the operation of section 1861(g).

18 “(B) THERAPY PROVIDER.—The term  
19 ‘therapy provider’ means a provider of services  
20 (as defined in section 1861(u)) or a supplier (as  
21 defined in section 1861(d)) who submits a claim  
22 for outpatient therapy services.

23 “(11) FUNDING.—For purposes of imple-  
24 menting this subsection, the Secretary shall provide  
25 for the transfer, from the Federal Supplementary

1 Medical Insurance Trust Fund under section 1841,  
2 of \$35,000,000 to the Centers for Medicare & Med-  
3 icaid Services Program Management Account for  
4 each fiscal year (beginning with fiscal year 2014).  
5 Amounts transferred under this paragraph shall re-  
6 main available until expended.

7 “(12) SCALING BACK.—

8 “(A) PERIODIC DETERMINATIONS.—Begin-  
9 ning with 2017, and every two years thereafter,  
10 the Secretary shall—

11 “(i) make a determination of the im-  
12 proper payment rate for outpatient therapy  
13 services for a 12-month period; and

14 “(ii) make such determination publicly  
15 available.

16 “(B) SCALING BACK.—If the improper  
17 payment rate for outpatient therapy services de-  
18 termined for a 12-month period under subpara-  
19 graph (A) is 50 percent or less of the Medicare  
20 fee-for-service improper payment rate for such  
21 period, the Secretary shall—

22 “(i) reduce the amount and extent of  
23 medical review conducted for a prospective  
24 year under the process established in this  
25 subsection; and

1 “(ii) return an appropriate portion of  
2 the funding provided for such year under  
3 paragraph (11).”.

4 (2) GAO STUDY AND REPORT.—

5 (A) STUDY.—The Comptroller General of  
6 the United States shall conduct a study on the  
7 effectiveness of medical review of outpatient  
8 therapy services under section 1833(aa) of the  
9 Social Security Act, as added by paragraph (1).  
10 Such study shall include an analysis of—

11 (i) aggregate data on—

12 (I) the number of individuals,  
13 therapy providers, and claims subject  
14 to such review; and

15 (II) the number of reviews con-  
16 ducted under such section; and

17 (ii) the outcomes of such reviews.

18 (B) REPORT.—Not later than 3 years after  
19 the date of enactment of this Act, the Com-  
20 ptroller General shall submit to Congress a re-  
21 port containing the results of the study under  
22 subparagraph (A), together with recommenda-  
23 tions for such legislation and administrative ac-  
24 tion as the Comptroller General determines ap-  
25 propriate.

1       (c) COLLECTION OF STANDARDIZED DATA ELE-  
2 MENTS FOR OUTPATIENT THERAPY SERVICES.—

3           (1) COLLECTION OF STANDARDIZED DATA ELE-  
4 MENTS FOR OUTPATIENT THERAPY SERVICES.—Sec-  
5 tion 1834 of the Social Security Act (42 U.S.C.  
6 1395m) is amended by adding at the end the fol-  
7 lowing new subsection:

8       “(p) COLLECTION OF STANDARDIZED DATA ELE-  
9 MENTS FOR OUTPATIENT THERAPY SERVICES.—

10           “(1) STANDARDIZED DATA ELEMENTS.—

11               “(A) IN GENERAL.—Not later than 6  
12 months after the date of enactment of this sub-  
13 section, the Secretary shall post on the Internet  
14 website of the Centers for Medicare & Medicaid  
15 Services a draft list of standardized data ele-  
16 ments for individuals receiving outpatient ther-  
17 apy services.

18               “(B) DOMAINS.—Such standardized data  
19 elements shall include information with respect  
20 to the following domains, as determined appro-  
21 priate by the Secretary:

22                   “(i) Demographic information.

23                   “(ii) Diagnosis.

24                   “(iii) Severity.



1                   “(iv) Affected body structures and  
2                   functions.

3                   “(v) Limitations with activities of  
4                   daily living and participation.

5                   “(vi) Functional status.

6                   “(vii) Other domains determined to be  
7                   appropriate by the Secretary.

8                   “(C) SOLICITATION OF INPUT.—The Sec-  
9                   retary shall accept comments from stakeholders  
10                  through the date that is 60 days after the date  
11                  the Secretary posts the draft list of standard-  
12                  ized data elements pursuant to subparagraph  
13                  (A). In seeking such comments, the Secretary  
14                  shall use one or more mechanisms to solicit  
15                  input from stakeholders that may include use of  
16                  open door forums, town hall meetings, requests  
17                  for information, or other mechanisms deter-  
18                  mined appropriate by the Secretary.

19                  “(D) OPERATIONAL LIST OF STANDARD-  
20                  IZED DATA ELEMENTS.—Not later than 120  
21                  days after the end of the comment period de-  
22                  scribed in subparagraph (C), the Secretary, tak-  
23                  ing into account such comments, shall post on  
24                  the Internet website of the Centers for Medi-

1 care & Medicaid Services an operational list of  
2 standardized data elements.

3 “(E) SUBSEQUENT REVISIONS.—Subse-  
4 quent revisions to the operational list of stand-  
5 ardized data elements shall be made through  
6 rulemaking. Such revisions may be based on ex-  
7 perience and input from stakeholders.

8 “(2) SYSTEM TO REPORT STANDARDIZED DATA  
9 ELEMENTS.—

10 “(A) IN GENERAL.—Not later than 18  
11 months after the date the Secretary posts the  
12 operational list of standardized data elements  
13 pursuant to paragraph (1)(D), the Secretary  
14 shall develop and implement an electronic sys-  
15 tem (which may be a web portal) for therapy  
16 providers to report the standardized data ele-  
17 ments for individuals with respect to outpatient  
18 therapy services.

19 “(B) CONSULTATION.—The Secretary  
20 shall seek comments from stakeholders regard-  
21 ing the best way to report the standardized  
22 data elements.

23 “(3) REPORTING.—

24 “(A) FREQUENCY OF REPORTING.—The  
25 Secretary shall specify the frequency of report-

1 ing standardized data elements. The Secretary  
2 shall seek comments from stakeholders regard-  
3 ing the frequency of the reporting of such data  
4 elements.

5 “(B) REPORTING REQUIREMENT.—Begin-  
6 ning on the date the system to report standard-  
7 ized data elements under this subsection is  
8 operational, no payment shall be made under  
9 this part for outpatient therapy services fur-  
10 nished to an individual unless a therapy pro-  
11 vider reports the standardized data elements for  
12 such individual.

13 “(4) REPORT ON NEW PAYMENT SYSTEM FOR  
14 OUTPATIENT THERAPY SERVICES.—

15 “(A) IN GENERAL.—Not later than 24  
16 months after the date described in paragraph  
17 (3)(B), the Secretary shall submit to Congress  
18 a report on the design of a new payment system  
19 for outpatient therapy services. The report shall  
20 include an analysis of the standardized data ele-  
21 ments collected and other appropriate data and  
22 information.

23 “(B) FEATURES.—Such report shall con-  
24 sider—

1 “(i) appropriate adjustments to pay-  
2 ment (such as case mix and outliers);

3 “(ii) payments on an episode of care  
4 basis; and

5 “(iii) reduced payment for multiple  
6 episodes.

7 “(C) CONSULTATION.—The Secretary shall  
8 consult with stakeholders regarding the design  
9 of such a new payment system.

10 “(5) IMPLEMENTATION.—

11 “(A) FUNDING.—For purposes of imple-  
12 menting this subsection, the Secretary shall  
13 provide for the transfer, from the Federal Sup-  
14plementary Medical Insurance Trust Fund  
15 under section 1841, of \$7,000,000 to the Cen-  
16ters for Medicare & Medicaid Services Program  
17 Management Account for each of fiscal years  
18 2014 through 2018. Amounts transferred under  
19 this subparagraph shall remain available until  
20 expended.

21 “(B) ADMINISTRATION.—Chapter 35 of  
22 title 44, United States Code, shall not apply to  
23 specification of the standardized data elements  
24 and implementation of the system to report

1 such standardized data elements under this  
 2 subsection.

3 “(C) LIMITATION.—There shall be no ad-  
 4 ministrative or judicial review under section  
 5 1869, section 1878, or otherwise of the speci-  
 6 fication of standardized data elements required  
 7 under this subsection or the system to report  
 8 such standardized data elements.

9 “(D) DEFINITION OF OUTPATIENT THER-  
 10 APY SERVICES AND THERAPY PROVIDER.—In  
 11 this subsection, the terms ‘outpatient therapy  
 12 services’ and ‘therapy provider’ have the mean-  
 13 ing given those term in section 1833(aa).”.

14 (2) SUNSET OF CURRENT CLAIMS-BASED COL-  
 15 LECTION OF THERAPY DATA.—Section 3005(g)(1) of  
 16 the Middle Class Tax Extension and Job Creation  
 17 Act of 2012 (42 U.S.C. 1395l note) is amended, in  
 18 the first sentence, by inserting “and ending on the  
 19 date the system to report standardized data ele-  
 20 ments under section 1834(p) of the Social Security  
 21 Act (42 U.S.C. 1395m(p)) is implemented,” after  
 22 “January 1, 2013,”.

23 (d) REPORTING OF CERTAIN INFORMATION.—Sec-  
 24 tion 1842(t) of the Social Security Act (42 U.S.C.

1 1395u(t)) is amended by adding at the end the following  
 2 new paragraph:

3 “(3) Each request for payment, or bill submitted, by  
 4 a therapy provider (as defined in section 1833(aa)(10))  
 5 for an outpatient therapy service (as defined in such sec-  
 6 tion) furnished by a therapy assistant on or after January  
 7 1, 2015, shall include (in a form and manner specified  
 8 by the Secretary) an indication that the service was fur-  
 9 nished by a therapy assistant.”.

10 **SEC. 203. MEDICARE AMBULANCE SERVICES.**

11 (a) EXTENSION OF CERTAIN AMBULANCE ADD-ON  
 12 PAYMENTS.—

13 (1) GROUND AMBULANCE.—Section  
 14 1834(l)(13)(A) of the Social Security Act (42 U.S.C.  
 15 1395m(l)(13)(A)) is amended by striking “April 1,  
 16 2014” and inserting “January 1, 2019” each place  
 17 it appears.

18 (2) SUPER RURAL AMBULANCE.—Section  
 19 1834(l)(12)(A) of the Social Security Act (42 U.S.C.  
 20 1395m(l)(12)(A)) is amended, in the first sentence,  
 21 by striking “April 1, 2014” and inserting “January  
 22 1, 2019”.

23 (b) REQUIRING AMBULANCE PROVIDERS TO SUBMIT  
 24 COST AND OTHER INFORMATION.—Section 1834(l) of the

1 Social Security Act (42 U.S.C. 1395m(l)) is amended by  
2 adding at the end the following new paragraph:

3 “(16) SUBMISSION OF COST AND OTHER INFOR-  
4 MATION.—

5 “(A) DEVELOPMENT OF DATA COLLECTION  
6 SYSTEM.—The Secretary shall develop a data  
7 collection system (which may include use of a  
8 cost survey and standardized definitions) for  
9 providers and suppliers of ambulance services to  
10 collect cost, revenue, utilization, and other in-  
11 formation determined appropriate by the Sec-  
12 retary. Such system shall be designed to submit  
13 information—

14 “(i) needed to evaluate the appro-  
15 priateness of payment rates under this  
16 subsection;

17 “(ii) on the utilization of capital  
18 equipment and ambulance capacity; and

19 “(iii) on different types of ambulance  
20 services furnished in different geographic  
21 locations, including rural areas and low  
22 population density areas described in para-  
23 graph (12).

24 “(B) SPECIFICATION OF DATA COLLEC-  
25 TION SYSTEM.—

1 “(i) IN GENERAL.—Not later than  
2 July 1, 2015, the Secretary shall—

3 “(I) specify the data collection  
4 system under subparagraph (A) and  
5 the time period during which such  
6 data is required to be submitted; and

7 “(II) identify the providers and  
8 suppliers of ambulance services who  
9 would be required to submit the infor-  
10 mation under such data collection sys-  
11 tem.

12 “(ii) RESPONDENTS.—Subject to sub-  
13 paragraph (D)(ii), the Secretary shall de-  
14 termine an appropriate sample of providers  
15 and suppliers of ambulance services to sub-  
16 mit information under the data collection  
17 system for each period for which reporting  
18 of data is required.

19 “(C) PENALTY FOR FAILURE TO REPORT  
20 COST AND OTHER INFORMATION.—Beginning  
21 on July 1, 2016, a 5 percent reduction to pay-  
22 ments under this part shall be made for a 1-  
23 year prospective period specified by the Sec-  
24 retary to a provider or supplier of ambulance  
25 services who—



1 “(i) is identified under subparagraph  
2 (B)(i)(II) as being required to submit the  
3 information under the data collection sys-  
4 tem; and

5 “(ii) does not submit such information  
6 during the period specified under subpara-  
7 graph (B)(i)(I).

8 “(D) ONGOING DATA COLLECTION.—

9 “(i) REVISION OF DATA COLLECTION  
10 SYSTEM.—The Secretary may, as deter-  
11 mined appropriate, periodically revise the  
12 data collection system.

13 “(ii) SUBSEQUENT DATA COLLEC-  
14 TION.—In order to continue to evaluate  
15 the appropriateness of payment rates  
16 under this subsection, the Secretary shall,  
17 for years after 2016 (but not less often  
18 than once every 3 years), require providers  
19 and suppliers of ambulance services to sub-  
20 mit information for a period the Secretary  
21 determines appropriate. The penalty de-  
22 scribed in subparagraph (C) shall apply to  
23 such subsequent data collection periods.

24 “(E) CONSULTATION.—The Secretary shall  
25 consult with stakeholders in carrying out the

1 development of the system and collection of in-  
2 formation under this paragraph, including the  
3 activities described in subparagraphs (A) and  
4 (D). Such consultation shall include the use of  
5 requests for information and other mechanisms  
6 determined appropriate by the Secretary.

7 “(F) ADMINISTRATION.—Chapter 35 of  
8 title 44, United States Code, shall not apply to  
9 the collection of information required under this  
10 subsection.

11 “(G) LIMITATIONS ON REVIEW.—There  
12 shall be no administrative or judicial review  
13 under section 1869, section 1878, or otherwise  
14 of the data collection system or identification of  
15 respondents under this paragraph.

16 “(H) FUNDING FOR IMPLEMENTATION.—  
17 For purposes of carrying out subparagraph (A),  
18 the Secretary shall provide for the transfer,  
19 from the Federal Supplementary Medical Insur-  
20 ance Trust Fund under section 1841, of  
21 \$1,000,000 to the Centers for Medicare & Med-  
22 icaid Services Program Management Account  
23 for fiscal year 2014. Amounts transferred under  
24 this subparagraph shall remain available until  
25 expended.”.

1 **SEC. 204. REVISION OF THE MEDICARE-DEPENDENT HOS-**  
 2 **PITAL (MDH) PROGRAM.**

3 (a) PERMANENT EXTENSION OF PAYMENT METHOD-  
 4 OLOGY.—

5 (1) IN GENERAL.—Section 1886(d)(5)(G) of  
 6 the Social Security Act (42 U.S.C.  
 7 1395ww(d)(5)(G)) is amended—

8 (A) in clause (i), by striking “and before  
 9 April 1, 2014,”; and

10 (B) in clause (ii)(II), by striking “and be-  
 11 fore April 1, 2014,”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) TARGET AMOUNT.—Section  
 14 1886(b)(3)(D) of the Social Security Act (42  
 15 U.S.C. 1395ww(b)(3)(D)) is amended—

16 (i) in the matter preceding clause (i),  
 17 by striking “and before April 1, 2014,”;  
 18 and

19 (ii) in clause (iv), by striking  
 20 “through fiscal year 2013 and the portion  
 21 of fiscal year 2014 before April 1, 2014”  
 22 and inserting “or a subsequent fiscal  
 23 year”.

24 (B) HOSPITAL VALUE-BASED PURCHASING  
 25 PROGRAM.—Section 1886(o)(7)(D)(ii)(I) of the  
 26 Social Security Act (42 U.S.C.

1           1395ww(o)(7)(D)(ii)(I)) is amended by striking  
 2           “(with respect to discharges occurring during  
 3           fiscal year 2012 and 2013)”.

4           (C) HOSPITAL READMISSION REDUCTION  
 5           PROGRAM.—Section 1886(q)(2)(B)(i) of the So-  
 6           cial Security Act (42 U.S.C.  
 7           1395ww(q)(2)(B)(i)) is amended by striking  
 8           “(with respect to discharges occurring during  
 9           fiscal years 2012 and 2013)”.

10           (D) PERMITTING HOSPITALS TO DECLINE  
 11           RECLASSIFICATION.—Section 13501(e)(2) of  
 12           the Omnibus Budget Reconciliation Act of 1993  
 13           (42 U.S.C. 1395ww note) is amended by strik-  
 14           ing “fiscal year 1998, fiscal year 1999, or fiscal  
 15           year 2000 through the first 2 quarters of fiscal  
 16           year 2014” and inserting “or fiscal year 1998  
 17           or a subsequent fiscal year”.

18           (b) GAO STUDY AND REPORT ON MEDICARE-DE-  
 19           PENDENT HOSPITALS.—

20           (1) STUDY.—The Comptroller General of the  
 21           United States shall conduct a study on the following:

22           (A) The payor mix of medicare-dependent,  
 23           small rural hospitals (as defined in section  
 24           1886(d)(5)(G)(iv)), how such mix will trend in  
 25           future years, and whether or not the require-

1           ment under subclause (IV) of such section  
2           should be revised.

3           (B) The characteristics of medicare-de-  
4           pendent, small rural hospitals that meet the re-  
5           quirement of such subclause (IV) through the  
6           application of paragraph (a)(iii)(A) or  
7           (a)(iii)(B) of section 412.108 of the Code of  
8           Federal Regulations, including Medicare inpa-  
9           tient and outpatient utilization, payor mix, and  
10          financial status, including Medicare and total  
11          margins, and whether or not Medicare pay-  
12          ments for such hospitals should be revised.

13          (C) Such other items related to medicare-  
14          dependent, small rural hospitals as the Comp-  
15          troller General determines appropriate.

16          (2) REPORT.—Not later than 12 months after  
17          the date of the enactment of this Act, the Comp-  
18          troller General of the United States shall submit to  
19          Congress a report on the study conducted under  
20          paragraph (1), together with recommendations for  
21          such legislation and administrative action as the  
22          Comptroller General determines appropriate.

23          (c) IMPLEMENTATION.—Notwithstanding any other  
24          provision of law, for purposes of fiscal year 2014, the Sec-  
25          retary of Health and Human Services may implement the

1 provisions of, and the amendments made by, this section  
 2 through program instruction or otherwise.

3 **SEC. 205. REVISION OF MEDICARE INPATIENT HOSPITAL**  
 4 **PAYMENT ADJUSTMENT FOR LOW-VOLUME**  
 5 **HOSPITALS.**

6 (a) IN GENERAL.—Section 1886(d)(12) of the Social  
 7 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

8 (1) in subparagraph (B)—

9 (A) in the subparagraph heading, by in-  
 10 sserting “FOR FISCAL YEARS 2005 THROUGH  
 11 2010” after “INCREASE”; and

12 (B) in the matter preceding clause (i), by  
 13 striking “and for discharges occurring in the  
 14 portion of fiscal year 2014 beginning on April  
 15 1, 2014, fiscal year 2015, and subsequent  
 16 years”;

17 (2) in subparagraph (C)(i)—

18 (A) by striking “fiscal years 2011, 2012,  
 19 and 2013, and the portion of fiscal year 2014  
 20 before” and inserting “fiscal year 2011 and  
 21 subsequent fiscal years,” each place it appears;  
 22 and

23 (B) by striking “or portion of fiscal year”  
 24 after “during the fiscal year”; and

25 (3) in subparagraph (D)—

1 (A) in the heading, by striking “TEM-  
 2 PORARY APPLICABLE PERCENTAGE INCREASE”  
 3 and inserting “APPLICABLE PERCENTAGE IN-  
 4 CREASE FOR FISCAL YEAR 2011 AND SUBSE-  
 5 QUENT FISCAL YEARS”;

6 (B) by striking “fiscal years 2011, 2012,  
 7 and 2013, and the portion of fiscal year 2014  
 8 before April 1, 2014” and inserting “fiscal year  
 9 2011 or a subsequent fiscal year”; and

10 (C) by striking “or the portion of fiscal  
 11 year” after “in the fiscal year”.

12 (b) IMPLEMENTATION.—Notwithstanding any other  
 13 provision of law, for purposes of fiscal year 2014, the Sec-  
 14 retary of Health and Human Services may implement the  
 15 provisions of, and the amendments made by, this section  
 16 through program instruction or otherwise.

17 **SEC. 206. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**  
 18 **SPECIAL NEEDS INDIVIDUALS.**

19 (a) EXTENSION.—Section 1859(f)(1) of the Social  
 20 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended—

21 (1) by striking “ENROLLMENT.—In the case”  
 22 and inserting “ENROLLMENT.—

23 “(A) IN GENERAL.—Subject to subpara-  
 24 graphs (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:



1           “(8) INCREASED INTEGRATION OF DUAL  
2       SNPS.—

3           “(A) DESIGNATED CONTACT.—The Sec-  
4       retary, acting through the Federal Coordinated  
5       Health Care Office (Medicare-Medicaid Coordi-  
6       nation Office) established under section 2602 of  
7       the Patient Protection and Affordable Care Act  
8       (in this paragraph referred to as the ‘MMCO’),  
9       shall serve as a dedicated point of contact for  
10      States to address misalignments that arise with  
11      the integration of specialized MA plans for spe-  
12      cial needs individuals described in subsection  
13      (b)(6)(B)(ii) under this paragraph. Consistent  
14      with such role, the MMCO shall—

15           “(i) establish a uniform process for  
16      disseminating to State Medicaid agencies  
17      information under this title impacting con-  
18      tracts between such agencies and such  
19      plans under this subsection; and

20           “(ii) establish basic resources for  
21      States interested in exploring such plans  
22      as a platform for integration.

23           “(B) UNIFIED GRIEVANCES AND APPEALS  
24      PROCESS.—

1 “(i) IN GENERAL.—Not later than  
2 April 1, 2015, the Secretary shall establish  
3 procedures unifying the grievances and ap-  
4 peals procedures under sections 1852(f),  
5 1852(g), 1902(a)(3), and 1902(a)(5) for  
6 items and services provided by specialized  
7 MA plans for special needs individuals de-  
8 scribed in subsection (b)(6)(B)(ii) under  
9 this title and title XIX. The Secretary  
10 shall solicit comment in developing such  
11 procedures from States, plans, beneficiary  
12 representatives, and other relevant stake-  
13 holders.

14 “(ii) PROCEDURES.—The procedures  
15 established under clause (i) shall—

16 “(I) adopt the most protective  
17 provisions for the enrollee under cur-  
18 rent law, including continuation of  
19 benefits under title XIX pending ap-  
20 peal if an appeal is filed in a timely  
21 manner;

22 “(II) take into account dif-  
23 ferences in State plans under title  
24 XIX;

1 “(III) be easily navigable by an  
2 enrollee; and

3 “(IV) include the elements de-  
4 scribed in clause (iii).

5 “(iii) ELEMENTS DESCRIBED.—The  
6 following elements are described in this  
7 clause:

8 “(I) Single notification of all ap-  
9 plicable grievances and appeal rights  
10 under this title and title XIX.

11 “(II) Notices written in plain lan-  
12 guage and available in a language and  
13 format that is accessible to the en-  
14 rollee.

15 “(III) Unified timeframes for in-  
16 ternal and external grievances and ap-  
17 peals processes, such as an individ-  
18 ual’s filing of a grievance or appeal, a  
19 plan’s acknowledgment and resolution  
20 of a grievance or appeal, and notifica-  
21 tion of decisions with respect to a  
22 grievance or appeal.

23 “(IV) Guidelines to allow the  
24 plan to process, track, and resolve  
25 grievances and appeals, to ensure

1 beneficiaries are notified on a timely  
2 basis of decisions that are made  
3 throughout the grievance or appeals  
4 process and are able to easily deter-  
5 mine the status of a grievance or ap-  
6 peal.

7 “(C) REQUIREMENT FOR UNIFIED GRIEV-  
8 ANCES AND APPEALS.—

9 “(i) IN GENERAL.—For 2016 and  
10 subsequent years, the contract of a special-  
11 ized MA plan for special needs individuals  
12 described in subsection (b)(6)(B)(ii) with a  
13 State Medicaid agency under this sub-  
14 section shall require the use of unified  
15 grievances and appeals procedures as de-  
16 scribed in subparagraph (B).

17 “(ii) CONSIDERATION OF APPLICA-  
18 TION FOR OTHER SNPS.—The Secretary  
19 shall consider applying the unified griev-  
20 ances and appeals process described in  
21 subparagraph (B) to specialized MA plans  
22 for special needs individuals described in  
23 subsection (b)(6)(B)(i) and subsection  
24 (b)(6)(B)(iii) that have a substantial por-  
25 tion 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 INTEGRA-  
TION FOR CERTAIN DUAL SNPS.—

“(i) REQUIREMENT.—Subject to the  
succeeding provisions of this subparagraph,  
for 2018 and subsequent years, a special-  
ized 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 sec-  
tion 1853(a)(1)(B)(iv)(II) (other than  
the requirement that the plan have  
similar average levels of frailty, as de-  
termined by the Secretary, as the  
PACE program), including with re-  
spect to long-term care services or be-  
havioral health services to the extent  
State law permits capitation of those  
services under such plan.

1           “(ii) INITIAL SANCTIONS FOR FAIL-  
2           URE TO MEET REQUIREMENT FOR 2018 OR  
3           2019.—For each of 2018 and 2019, if the  
4           Secretary determines that a plan has failed  
5           to meet the requirement described in  
6           clause (i), the Secretary shall impose one  
7           of the following on the plan:

8                   “(I) A reduction in payment to  
9                   the plan under this part in an amount  
10                  at least equal to the portion of the  
11                  monthly rebate computed under sec-  
12                  tion 1854(b)(1)(C)(i) for the plan and  
13                  year that would otherwise be kept by  
14                  the plan after application of the bene-  
15                  ficiary rebate rule under section  
16                  1854(b)(1)(C).

17                  “(II) Closing enrollment in the  
18                  plan.

19                  “(III) Sanctioning the plan in ac-  
20                  cordance with section 1857(g).

21                  “(IV) Other reasonable action  
22                  (other than the sanction described in  
23                  clause (iii)) the Secretary determines  
24                  appropriate.

1 “(iii) SANCTIONS FOR FAILURE TO  
2 MEET REQUIREMENT FOR 2020 AND SUBSE-  
3 QUENT YEARS.—For 2020 and subsequent  
4 years, if the Secretary determines that a  
5 plan has failed to meet the requirement de-  
6 scribed in clause (i), the plan shall be  
7 deemed to no longer meet the definition of  
8 a specialized MA plan for special needs in-  
9 dividuals described in subsection  
10 (b)(6)(B)(ii).

11 “(iv) LIMITATION.—This subpara-  
12 graph shall not apply to a specialized MA  
13 plan for special needs individuals described  
14 in subsection (b)(6)(B)(ii) that only enrolls  
15 individuals for whom the only medical as-  
16 sistance to which the individuals are enti-  
17 tled under the State plan is medicare cost  
18 sharing described in section  
19 1905(p)(3)(A)(ii).”.

20 (2) CONFORMING AMENDMENT TO RESPON-  
21 SIBILITIES OF FEDERAL COORDINATED HEALTH  
22 CARE OFFICE (MMCO).—Section 2602(d) of the Pa-  
23 tient Protection and Affordable Care Act (42 U.S.C.  
24 1315b(d)) is amended by adding at the end the fol-  
25 lowing new paragraph:

1           “(6) To act as a designated contact for States  
 2           under subsection (f)(8)(A) of section 1859 of the So-  
 3           cial Security Act (42 U.S.C. 1395w–28) with respect  
 4           to the integration of specialized MA plans for special  
 5           needs individuals described in subsection  
 6           (b)(6)(B)(ii) of such section.”.

7           (c) IMPROVEMENTS TO SEVERE OR DISABLING  
 8           CHRONIC CONDITION SNPS.—Section 1859(f)(5) of the  
 9           Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amend-  
 10          ed—

11           (1) by striking “ALL SNPS.—The requirements”  
 12          and inserting “ALL SNPS.—

13                   “(A) IN GENERAL.—Subject to subpara-  
 14                  graph (B), the requirements”;

15           (2) by redesignating subparagraphs (A) and  
 16           (B) as clauses (i) and (ii), respectively, and indent-  
 17          ing appropriately;

18           (3) in clause (ii), as redesignated by paragraph  
 19           (2), by redesignating clauses (i) through (iii) as sub-  
 20           clauses (I) through (III), respectively, and indenting  
 21          appropriately; and

22           (4) by adding at the end the following new sub-  
 23          paragraph:

24                   “(B) IMPROVEMENTS TO CARE MANAGE-  
 25                  MENT REQUIREMENTS FOR SEVERE OR DIS-



1 ABLING CHRONIC CONDITION SNPS.—For 2016  
2 and subsequent years, in the case of a special-  
3 ized MA plan for special needs individuals de-  
4 scribed in subsection (b)(6)(B)(iii), the require-  
5 ments described in this paragraph include the  
6 following:

7 “(i) The interdisciplinary team under  
8 subparagraph (A)(ii)(III) includes a team  
9 of providers with demonstrated expertise,  
10 including training in an applicable spe-  
11 cialty, in treating individuals similar to the  
12 targeted population of the plan.

13 “(ii) Requirements developed by the  
14 Secretary to provide face-to-face encoun-  
15 ters with individuals enrolled in the plan  
16 not less frequently than on an annual  
17 basis.

18 “(iii) As part of the model of care  
19 under clause (i) of subparagraph (A), the  
20 results of the initial assessment and an-  
21 nual reassessment under clause (ii)(I) of  
22 such subparagraph of each individual en-  
23 rolled in the plan are addressed in the indi-  
24 vidual’s individualized care plan under  
25 clause (ii)(II) of such subparagraph.

1                   “(iv) As part of the annual evaluation  
 2                   and approval of such model of care, the  
 3                   Secretary shall take into account whether  
 4                   the plan fulfilled the previous year’s goals  
 5                   (as required under the model of care).

6                   “(v) The Secretary shall establish a  
 7                   minimum benchmark for each element of  
 8                   the model of care of a plan. The Secretary  
 9                   shall only approve a plan’s model of care  
 10                  under this paragraph if each element of  
 11                  the model of care meets the minimum  
 12                  benchmark applicable under the preceding  
 13                  sentence.”.

14                  (d) GAO STUDY ON QUALITY IMPROVEMENT.—

15                  (1) STUDY.—The Comptroller General of the  
 16                  United States shall conduct a study on how the Sec-  
 17                  retary of Health and Human Services could change  
 18                  the quality measurement system under the Medicare  
 19                  Advantage program under part C of title XVIII of  
 20                  the Social Security Act (42 U.S.C. 1395w–21 et  
 21                  seq.) to allow an accurate comparison of the quality  
 22                  of care provided by specialized MA plans for special  
 23                  needs individuals (as defined in section 1859(b)(6)  
 24                  of such Act (42 U.S.C. 1395w–28(b)(6)), both for  
 25                  individual plans and such plans overall, compared to

1 the quality of care delivered by the original Medicare  
 2 fee-for-service program under parts A and B of such  
 3 title and other Medicare Advantage plans under such  
 4 part C across similar populations.

5 (2) REPORT.—Not later than July 1, 2016, the  
 6 Comptroller General shall submit to Congress a re-  
 7 port containing the results of the study under para-  
 8 graph (1), together with recommendations for such  
 9 legislation and administrative action as the Comp-  
 10 troller General determines appropriate.

11 (e) CHANGES TO QUALITY RATINGS AND MEASURE-  
 12 MENT OF SNPs AND DETERMINATION OF FEASIBILITY  
 13 OF QUALITY MEASUREMENT AT THE PLAN LEVEL.—Sec-  
 14 tion 1853(o) of the Social Security Act (42 U.S.C. 1395w-  
 15 23(o)) is amended by adding at the end the following new  
 16 paragraphs:

17 “(6) CHANGES TO QUALITY RATINGS OF  
 18 SNPS.—

19 “(A) EMPHASIS ON IMPROVEMENT ACROSS  
 20 SNPS.—Subject to subparagraph (B), beginning  
 21 in plan year 2016, in the case of a specialized  
 22 MA plan for special needs individuals, the Sec-  
 23 retary shall increase the emphasis on the plan’s  
 24 improvement or decline in performance when

1 determining the star rating of the plan under  
2 this subsection for the year as follows:

3 “(i)(I) For plan year 2016, at least  
4 10 percent, but not more than 12 percent,  
5 of the total star rating of the plan shall be  
6 based on improvement or decline in per-  
7 formance.

8 “(II) For plan year 2017 and subse-  
9 quent plan years, at least 12 percent, but  
10 not more than 15 percent, of the total star  
11 rating of the plan shall be based on im-  
12 provement or decline in performance.

13 “(ii) Improvement or decline in per-  
14 formance under this subparagraph shall be  
15 measured based on net change in the indi-  
16 vidual star rating measures of the plan,  
17 with appropriate weight given to specific  
18 individual star ratings measures, such as  
19 readmission rates, as determined by the  
20 Secretary.

21 “(iii) The Secretary shall make an ap-  
22 propriate adjustment to the improvement  
23 rating of a plan under this subparagraph  
24 if the plan has achieved a 4.5-star rating  
25 or the highest rating possible overall or for

1 an individual measure in order to ensure  
2 that the plan is not punished in cases  
3 where it is not possible to improve.

4 “(B) NO APPLICATION TO CERTAIN  
5 PLANS.—Subparagraph (A) shall not apply,  
6 with respect to a year, to a specialized MA plan  
7 for special needs individuals that has a rating  
8 that is less than two-and-one-half stars.

9 “(C) QUALITY MEASUREMENT AT THE  
10 PLAN LEVEL.—

11 “(i) IN GENERAL.—The Secretary  
12 may require reporting for and apply under  
13 this subsection quality measures at the  
14 plan level for specialized MA plan for spe-  
15 cial needs individuals instead of at the con-  
16 tract level.

17 “(ii) CONSIDERATION.—The Secretary  
18 shall take into consideration the minimum  
19 number of enrollees in a specialized MA  
20 plan for special needs individuals in order  
21 to determine if a statistically significant or  
22 valid measurement of quality at the plan  
23 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 measurement (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

1 (A), the Secretary shall consider requiring such  
 2 reporting and applying such quality measures  
 3 at the plan level as described in such subpara-  
 4 graph.”.

5 **SEC. 207. REASONABLE COST REIMBURSEMENT CON-**  
 6 **TRACTS.**

7 (a) ONE-YEAR TRANSITION AND NOTICE REGARDING  
 8 TRANSITION.—Section 1876(h)(5)(C) of the Social Secu-  
 9 rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

10 (1) in clause (ii), in the matter preceding sub-  
 11 clause (I), by striking “For any” and inserting  
 12 “Subject to clause (iv), for any”; and

13 (2) by adding at the end the following new  
 14 clauses:

15 “(iv) In the case of an eligible organization that is  
 16 offering a reasonable cost reimbursement contract that  
 17 may no longer be extended or renewed because of the ap-  
 18 plication of clause (ii), the following shall apply:

19 “(I) Notwithstanding such clause, such contract  
 20 may be extended or renewed for the two years subse-  
 21 quent to the previous year described in clause (ii).  
 22 The second of the two years described in the pre-  
 23 ceding sentence with respect to a contract is referred  
 24 to in this subsection as the ‘last reasonable cost re-  
 25 imbursement contract year for the contract’.

1           “(II) The organization may not enroll any new  
2           enrollees under such contract during the last reason-  
3           able cost reimbursement contract year for the con-  
4           tract.

5           “(III) Not later than a date determined appro-  
6           priate by the Secretary prior to the beginning of the  
7           last reasonable cost reimbursement contract year for  
8           the contract, the organization shall provide notice to  
9           the Secretary as to whether or not the organization  
10          will apply to have the contract converted over and  
11          offered as a Medicare Advantage plan under part C  
12          for the year following the last reasonable cost reim-  
13          bursement contract year for the contract.

14          “(IV) If the organization provides the notice de-  
15          scribed in subclause (III) that the contract will be  
16          converted, the organization shall, not later than a  
17          date determined appropriate by the Secretary, pro-  
18          vide the Secretary with such information as the Sec-  
19          retary determines appropriate in order to carry out  
20          sections 1851(c)(4) and 1854(a)(5), including sub-  
21          paragraph (C) of such section.

22          “(v) If an eligible organization that is offering a rea-  
23          sonable cost reimbursement contract that is extended or  
24          renewed pursuant to clause (iv) provides the notice de-



1 scribed in clause (iv)(III) that the contract will be con-  
 2 verted, the following provisions shall apply:

3 “(I) The deemed enrollment under section  
 4 1851(c)(4).

5 “(II) The special rule for quality increases  
 6 under 1853(o)(3)(A)(iv).”.

7 (b) DEEMED ENROLLMENT FROM REASONABLE  
 8 COST REIMBURSEMENT CONTRACTS CONVERTED TO  
 9 MEDICARE ADVANTAGE PLANS.—

10 (1) IN GENERAL.—Section 1851(c) of the So-  
 11 cial Security Act (42 U.S.C. 1395w–21(c)) is  
 12 amended—

13 (A) in paragraph (1), by striking “Such  
 14 elections” and inserting “Subject to paragraph  
 15 (4), such elections”; and

16 (B) by adding at the end the following:

17 “(4) DEEMED ENROLLMENT RELATING TO CON-  
 18 VERTED REASONABLE COST REIMBURSEMENT CON-  
 19 TRACTS.—

20 “(A) IN GENERAL.—On the first day of  
 21 the annual, coordinated election period under  
 22 subsection (e)(3) for plan years beginning on or  
 23 after January 1, 2017, an MA eligible indi-  
 24 vidual described in clause (i) or (ii) of subpara-  
 25 graph (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 owner-

1 ship interest of control) that entered  
2 into such contract; and

3 “(III) is offered in the service  
4 area where the individual resides;

5 “(v) the applicable MA plan provides  
6 benefits, premiums, and access to in-net-  
7 work and out-of-network providers that are  
8 comparable to the benefits, premiums, and  
9 access to in-network and out-of-network  
10 providers under such reasonable cost reim-  
11 bursement contract for the previous plan  
12 year; and

13 “(vi) the applicable MA plan—

14 “(I) allows enrollees transitioning  
15 from the converted reasonable cost  
16 contract to such plan to maintain cur-  
17 rent providers and course of treat-  
18 ment at the time of enrollment for at  
19 least 90 days after enrollment; and

20 “(II) during such period, pays  
21 non-contracting providers for items  
22 and services furnished to the enrollee  
23 an amount that is not less than the  
24 amount of payment applicable for  
25 those items and services under the

1 original medicare fee-for-service pro-  
2 gram under parts A and B.

3 “(B) MA ELIGIBLE INDIVIDUALS DE-  
4 SCRIBED.—

5 “(i) WITHOUT PRESCRIPTION DRUG  
6 COVERAGE.—An MA eligible individual de-  
7 scribed in this clause, with respect to a  
8 plan year, is an MA eligible individual who  
9 is enrolled in a reasonable cost reimburse-  
10 ment contract under section 1876(h) in the  
11 previous plan year and who does not, for  
12 such previous plan year, receive any pre-  
13 scription drug coverage under part D, in-  
14 cluding coverage under section 1860D–22.

15 “(ii) WITH PRESCRIPTION DRUG COV-  
16 ERAGE.—An MA eligible individual de-  
17 scribed in this clause, with respect to a  
18 plan year, is an MA eligible individual who  
19 is enrolled in a reasonable cost reimburse-  
20 ment contract under section 1876(h) in the  
21 previous plan year and who, for such pre-  
22 vious plan year, receives prescription drug  
23 coverage under part D—

24 “(I) through such contract; or

1 “(II) through a prescription drug  
 2 plan, if the sponsor of such plan is the  
 3 same entity (or an organization affili-  
 4 ated with such entity) that entered  
 5 into such contract.

6 “(C) APPLICABLE MA PLAN DEFINED.—In  
 7 this paragraph, the term ‘applicable MA plan’  
 8 means, in the case of an individual described  
 9 in—

10 “(i) subparagraph (B)(i), an MA plan  
 11 that is not an MA–PD plan; and

12 “(ii) subparagraph (B)(ii), an MA–  
 13 PD plan.

14 “(D) IDENTIFICATION AND NOTIFICATION  
 15 OF DEEMED INDIVIDUALS.—Not later than 30  
 16 days before the first day of the annual, coordi-  
 17 nated election period under subsection (e)(3)  
 18 for plan years beginning on or after January 1,  
 19 2017, the Secretary shall identify and notify the  
 20 individuals who will be subject to deemed elec-  
 21 tions under subparagraph (A) on the first day  
 22 of such period.”.

23 (2) BENEFICIARY OPTION TO DISCONTINUE OR  
 24 CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED  
 25 ENROLLMENT.—

1 (A) IN GENERAL.—Section 1851(e)(2) of  
2 the Social Security Act (42 U.S.C. 1395w–  
3 21(e)(4)) is amended by adding at the end the  
4 following:

5 “(F) SPECIAL PERIOD FOR CERTAIN  
6 DEEMED ELECTIONS.—

7 “(i) IN GENERAL.—At any time dur-  
8 ing the period beginning after the last day  
9 of the annual, coordinated election period  
10 under paragraph (3) in which an individual  
11 is deemed to have elected to enroll in an  
12 MA plan or MA–PD plan under subsection  
13 (c)(4) and ending on the last day of Feb-  
14 ruary of the first plan year for which the  
15 individual is enrolled in such plan, such in-  
16 dividual may change the election under  
17 subsection (a)(1) (including changing the  
18 MA plan or MA–PD plan in which the in-  
19 dividual is enrolled).

20 “(ii) LIMITATION OF ONE CHANGE.—  
21 An individual may exercise the right under  
22 clause (i) only once during the applicable  
23 period described in such clause. The limita-  
24 tion under this clause shall not apply to  
25 changes in elections effected during an an-

nual, 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:

1           “An individual who develops end-stage renal  
 2           disease while enrolled in a reasonable cost reim-  
 3           bursement contract under section 1876(h) shall  
 4           be treated as an MA eligible individual for pur-  
 5           poses of applying the deemed enrollment under  
 6           subsection (c)(4).”.

7           (c)       INFORMATION       REQUIREMENTS.—Section  
 8   1851(d)(2)(B) of the Social Security Act (42 U.S.C.  
 9   1395w–21(d)(2)(B)) is amended—

10           (1) by striking the subparagraph heading and  
 11       inserting the following: “(i) NOTIFICATION TO  
 12       NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE  
 13       INDIVIDUALS.—”; and

14           (2) by adding at the end the following:

15                   “(ii) NOTIFICATION RELATED TO CERTAIN  
 16       DEEMED ELECTIONS.—The Secretary shall re-  
 17       quire the converting cost plan to mail, not later  
 18       than 15 days prior to the first day of the an-  
 19       nual, coordinated election period under sub-  
 20       section (e)(3) of a year, to any individual iden-  
 21       tified by the Secretary under subsection  
 22       (c)(4)(D) for such year—

23                   “(I) a notification that such individual  
 24       will, on such day, be deemed to have made  
 25       an election to receive benefits under this



1 title through an MA plan or MA–PD plan  
 2 (and shall be enrolled in such plan) for the  
 3 next plan year under subsection (c)(4)(A),  
 4 but that the individual may make a dif-  
 5 ferent election during the annual, coordi-  
 6 nated election period for such year;

7 “(II) the information described in  
 8 subparagraph (A);

9 “(III) a description of the differences  
 10 between such MA plan or MA–PD plan  
 11 and the reasonable cost reimbursement  
 12 contract in which the individual was most  
 13 recently enrolled with respect to benefits  
 14 covered under such plans, including cost-  
 15 sharing, premiums, drug coverage, and  
 16 provider networks;

17 “(IV) information about the special  
 18 period for elections under subsection  
 19 (e)(2)(F); and

20 “(V) other information the Secretary  
 21 may specify”.

22 (d) TREATMENT OF TRANSITION PLAN FOR QUALITY  
 23 RATING FOR PAYMENT PURPOSES.—Section 1853(o)(4)  
 24 of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) is

1 amended by adding at the end the following new subpara-  
 2 graph:

3 “(C) SPECIAL RULE FOR FIRST 3 PLAN  
 4 YEARS FOR PLANS THAT WERE CONVERTED  
 5 FROM A REASONABLE COST REIMBURSEMENT  
 6 CONTRACT.—For purposes of applying para-  
 7 graph (1) and section 1854(b)(1)(C) for the  
 8 first 3 plan years under this part in the case of  
 9 an MA plan to which deemed enrollment applies  
 10 under section 1851(c)(4)—

11 “(i) such plan shall not be treated as  
 12 a new plan (as defined in paragraph  
 13 (3)(A)(iii)(II)); and

14 “(ii) in determining the star rating of  
 15 the plan under subparagraph (A), to the  
 16 extent that Medicare Advantage data for  
 17 such plan is not available for a measure  
 18 used to determine such star rating, the  
 19 Secretary shall use data from the period in  
 20 which such plan was a reasonable cost re-  
 21 imbursement contract.”.

22 **SEC. 208. QUALITY MEASURE ENDORSEMENT AND SELEC-**  
 23 **TION.**

24 (a) CONTRACT WITH AN ENTITY REGARDING INPUT  
 25 ON THE SELECTION OF MEASURES.—

1           (1) IN GENERAL.—Title XVIII of the Social Se-  
2           curity Act (42 U.S.C. 1395 et seq.) is amended—

3                   (A) by redesignating section 1890A as sec-  
4           tion 1890B; and

5                   (B) by inserting after section 1890 the fol-  
6           lowing new section:

7           “CONTRACT WITH AN ENTITY REGARDING INPUT ON THE  
8                               SELECTION OF MEASURES

9           “SEC. 1890A (a) CONTRACT.—

10                   “(1) IN GENERAL.—For purposes of activities  
11           conducted under this Act, the Secretary shall iden-  
12           tify and have in effect a contract with an entity that  
13           meets the requirements described in subsection (c).  
14           Such contract shall provide that the entity will per-  
15           form the duties described in subsection (b).

16                   “(2) TIMING FOR FIRST CONTRACT.—The first  
17           contract under paragraph (1) shall begin on, or as  
18           soon as practicable after, October 1, 2014.

19                   “(3) PERIOD OF CONTRACT.—A contract under  
20           paragraph (1) shall be for a period of 3 years (ex-  
21           cept as may be renewed after a subsequent bidding  
22           process).

23                   “(4) COMPETITIVE PROCEDURES.—Competitive  
24           procedures (as defined in section 4(5) of the Office  
25           of Federal Procurement Policy Act (41 U.S.C.

1       403(5))) shall be used to enter into a contract under  
2       paragraph (1).

3       “(b) DUTIES.—The duties described in this sub-  
4       section are the following:

5       “(c) REQUIREMENTS DESCRIBED.—The require-  
6       ments described in this subsection are the following:

7               “(1) PRIVATE NONPROFIT, BOARD MEMBER-  
8       SHIP, MEMBERSHIP FEES, AND NOT A MEASURE DE-  
9       VELOPER.—The requirements described in para-  
10       graphs (1), (2), (7), and (8) of section 1890(c).

11              “(2) EXPERIENCE.—The entity has at least 4  
12       years of experience working with quality and effi-  
13       ciency measures.”.

14       (2) DUTIES OF ENTITY.—

15              (A) TRANSFER OF PRIORITY SETTING  
16       PROCESS.—Paragraph (1) of section 1890(b) of  
17       the Social Security Act (42 U.S.C. 1395aaa(b))  
18       is redesignated as paragraph (1) of section  
19       1890A(b) of such Act, as added by paragraph  
20       (1).

21              (B) TRANSFER OF MULTI-STAKEHOLDER  
22       PROCESS.—Paragraphs (7) and (8) of such sec-  
23       tion 1890(b) are redesignated as paragraphs  
24       (2) and (3), respectively, of section 1890A(b) of

1           such Act, as added by paragraph (1) and  
2           amended by subparagraph (A).

3                   (C)       ADDITIONAL       DUTIES.—Section  
4           1890A(b) of such Act, as added by paragraph  
5           (1) and amended by subparagraphs (A) and  
6           (B), is amended by adding at the end the fol-  
7           lowing new paragraphs:

8           “(4) FACILITATION TO BETTER COORDINATE  
9           AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF  
10          QUALITY MEASURES.—

11                   “(A) IN GENERAL.—The entity shall facili-  
12          tate increased coordination and alignment be-  
13          tween the public and private sector with respect  
14          to quality and efficiency measures.

15                   “(B) REPORTS.—The entity shall prepare  
16          and make available to the public annual reports  
17          on its findings under this paragraph. Such pub-  
18          lic availability shall include posting each report  
19          on the Internet website of the entity.

20                   “(5) GAP ANALYSIS.—The entity shall conduct  
21          an ongoing analysis of—

22                   “(A) gaps in endorsed quality and effi-  
23          ciency measures, which shall include measures  
24          that are within priority areas identified by the  
25          Secretary under the national strategy estab-

1           lished under section 399HH of the Public  
2           Health Service Act; and

3           “(B) areas where quality measures are un-  
4           available or inadequate to identify or address  
5           such gaps.

6           “(6) ANNUAL REPORT TO CONGRESS AND THE  
7           SECRETARY; SECRETARIAL PUBLICATION AND COM-  
8           MENT.—

9           “(A) ANNUAL REPORT.—By not later than  
10          June 1 of each year, the entity shall submit to  
11          Congress and the Secretary a report con-  
12          taining—

13               “(i) a description of—

14                   “(I) the recommendations made  
15                   under paragraph (1);

16                   “(II) the matters described in  
17                   clauses (i) and (ii) of paragraph  
18                   (2)(A);

19                   “(III) the results of the analysis  
20                   under paragraph (5); and

21                   “(IV) the performance by the en-  
22                   tity of the duties required under the  
23                   contract entered into with the Sec-  
24                   retary under subsection (a); and

1 “(ii) any other items determined ap-  
 2 propriate by the Secretary.

3 “(B) SECRETARIAL REVIEW AND PUBLICA-  
 4 TION OF ANNUAL REPORT.—Not later than 6  
 5 months after receiving a report under subpara-  
 6 graph (A), the Secretary shall—

7 “(i) review such report; and

8 “(ii) publish such report in the Fed-  
 9 eral Register, together with any comments  
 10 of the Secretary on such report.”.

11 (D) ADDITIONAL AMENDMENTS.—Section  
 12 1890A(b) of such Act, as so added and amend-  
 13 ed, is amended—

14 (i) in paragraph (2)—

15 (I) in subparagraph (A)(i)—

16 (aa) in subclause (I), by in-  
 17 serting “with a contract under  
 18 section 1890” after “entity”; and

19 (bb) in subclause (II), by  
 20 striking “such entity” and insert-  
 21 ing “the entity with a contract  
 22 under section 1890”;

23 (II) in the heading of subpara-  
 24 graph (B) by inserting “AND EFFI-  
 25 CIENCY” after “QUALITY”;

1 (III) in subparagraph (B)(i)(III),  
2 by striking “this Act” and inserting  
3 “this title”; and

4 (IV) by adding at the end the fol-  
5 lowing new subparagraphs:

6 “(E) INPUT.—In providing the input de-  
7 scribed in subparagraph (A), the multi-stake-  
8 holder groups—

9 “(i) shall include a detailed descrip-  
10 tion of the rationale for each recommenda-  
11 tion made by the multi-stakeholder group,  
12 including in areas relating to—

13 “(I) the expected impact that im-  
14 plementing the measure will have on  
15 individuals;

16 “(II) the burden on providers of  
17 services and suppliers;

18 “(III) the expected influence over  
19 the behavior of providers of services  
20 and suppliers;

21 “(IV) the applicability of a meas-  
22 ure for more than one setting or pro-  
23 gram; and

24 “(V) other areas determined in  
25 consultation with the Secretary; and



1                   “(ii) may consider whether it is appro-  
 2                   priate to provide separate recommenda-  
 3                   tions with respect to measures for internal  
 4                   use, public reporting, and payment provi-  
 5                   sions.

6                   “(F) EQUAL REPRESENTATION.—In con-  
 7                   vening multi-stakeholder groups pursuant to  
 8                   this paragraph, the entity shall, to the extent  
 9                   feasible, make every effort to ensure such  
 10                  groups are balanced across stakeholders.”; and

11                  (ii) in paragraph (3), by striking “Not  
 12                  later” and all that follows through the pe-  
 13                  riod at the end and inserting the following:  
 14                  “Not later than the applicable dates de-  
 15                  scribed in section 1890B(a)(3) of each  
 16                  year (or, as applicable, the timeframe de-  
 17                  scribed in section 1890B(a)(4)), the entity  
 18                  shall transmit to the Secretary the input of  
 19                  the multi-stakeholder groups under para-  
 20                  graph (2).”.

21                  (b) REVISIONS TO CONTRACT WITH CONSENSUS-  
 22                  BASED ENTITY.—

23                  (1) CONTRACT.—Section 1890(a) of the Social  
 24                  Security Act (42 U.S.C. 1395aaa(a)) is amended—

1 (A) in paragraph (1), by striking “, such  
2 as the National Quality Forum,”; and

3 (B) in paragraph (3), by striking “4  
4 years” and inserting “3 years”.

5 (2) DUTIES.—Section 1890(b) of the Social Se-  
6 curity Act (42 U.S.C. 1395aaa(b)), as amended by  
7 subsection (a)(2), is amended—

8 (A) by redesignating paragraphs (2) and  
9 (3) as paragraphs (1) and (2), respectively;

10 (B) in paragraph (2), as redesignated by  
11 subparagraph (A), by striking “paragraph (2)”  
12 and inserting “paragraph (1)”;

13 (C) by striking paragraphs (5) and (6);  
14 and

15 (D) by adding at the end the following new  
16 paragraphs:

17 “(3) FACILITATION TO BETTER COORDINATE  
18 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF  
19 QUALITY MEASURES.—

20 “(A) IN GENERAL.—The entity shall facili-  
21 tate increased coordination and alignment be-  
22 tween the public and private sector with respect  
23 to quality and efficiency measures.

24 “(B) REPORTS.—The entity shall prepare  
25 and make available to the public annual reports

1           on its findings under this paragraph. Such pub-  
2           lic availability shall include posting each report  
3           on the Internet website of the entity.

4           “(4) ANNUAL REPORT TO CONGRESS AND THE  
5           SECRETARY; SECRETARIAL PUBLICATION AND COM-  
6           MENT.—

7                   “(A) ANNUAL REPORT.—By not later than  
8           March 1 of each year, the entity shall submit  
9           to Congress and the Secretary a report con-  
10          taining—

11                   “(i) a description of—

12                           “(I) the coordination of quality  
13                   initiatives under this title and titles  
14                   XIX and XXI with quality initiatives  
15                   implemented by other payers;

16                           “(II) areas in which evidence is  
17                   insufficient to support endorsement of  
18                   quality measures in priority areas  
19                   identified by the Secretary under the  
20                   national strategy established under  
21                   section 399HH of the Public Health  
22                   Service Act and where targeted re-  
23                   search may address such gaps; and

24                           “(III) the performance by the en-  
25                   tity of the duties required under the

1 contract entered into with the Sec-  
 2 retary under subsection (a); and

3 “(ii) any other items determined ap-  
 4 propriate by the Secretary.

5 “(B) SECRETARIAL REVIEW AND PUBLICA-  
 6 TION OF ANNUAL REPORT.—Not later than 6  
 7 months after receiving a report under subpara-  
 8 graph (A), the Secretary shall—

9 “(i) review such report; and

10 “(ii) publish such report in the Fed-  
 11 eral Register, together with any comments  
 12 of the Secretary on such report.”.

13 (3) REQUIREMENTS.—Section 1890(c) of the  
 14 Social Security Act (42 U.S.C. 1395aaa(c)) is  
 15 amended by adding at the end the following new  
 16 paragraph:

17 “(8) NOT A MEASURE DEVELOPER.—The entity  
 18 is not a measure developer.”.

19 (c) REVISIONS TO DUTIES OF THE SECRETARY RE-  
 20 GARDING USE OF MEASURES.—

21 (1) IN GENERAL.—Section 1890B(a) of the So-  
 22 cial Security Act (42 U.S.C. 1395aaa–1(a)), as re-  
 23 designated by subsection (a)(1)(A), is amended—

1 (A) by striking “section 1890(b)(7)(B)”  
2 each place it appears and inserting “section  
3 1890A(b)(2)(B)”;

4 (B) in paragraph (1)—

5 (i) by striking “section 1890(b)(7)”  
6 and inserting “section 1890A(b)(2)”; and

7 (ii) by striking “section 1890” and in-  
8 serting “section 1890A”;

9 (C) by striking paragraphs (2) and (3) and  
10 inserting the following:

11 “(2) PUBLIC AVAILABILITY OF MEASURES CON-  
12 sidered for selection.—Subject to paragraph  
13 (4), not later than October 1 or December 31 of  
14 each year (or as soon as practicable after such dates  
15 for the first year of the contract), the Secretary  
16 shall make available to the public a list of quality  
17 and efficiency measures described in section  
18 1890A(b)(2)(B) that the Secretary is considering  
19 under this title. The Secretary shall provide for an  
20 appropriate balance of the number of measures to be  
21 made available by each such date in a year.

22 “(3) TRANSMISSION OF MULTI-STAKEHOLDER  
23 INPUT.—

24 “(A) IN GENERAL.—Subject to paragraph  
25 (4), not later than the applicable date described

1 in subparagraph (B) of each year, the entity  
 2 with a contract under section 1890A shall, pur-  
 3 suant to subsection (b)(3) of such section,  
 4 transmit to the Secretary the input of multi-  
 5 stakeholder groups described in paragraph (1).

6 “(B) APPLICABLE DATE DESCRIBED.—The  
 7 applicable date described in this subparagraph  
 8 for a year is—

9 “(i) February 1 (or as soon as prac-  
 10 ticable after such date for the first year of  
 11 the contract) with respect to quality and  
 12 efficiency measures made available under  
 13 paragraph (2) by October 1 of the pre-  
 14 ceding year; and

15 “(ii) April 1 (or as soon as practicable  
 16 after such dates for the first year of the  
 17 contract) with respect to quality and effi-  
 18 ciency measures made available under  
 19 paragraph (2) by December 31 of the pre-  
 20 ceding year.”;

21 (D) by redesignating—

22 (i) paragraph (6) as paragraph (8);  
 23 and

24 (ii) paragraphs (4) and (5) as para-  
 25 graphs (5) and (6), respectively;

1 (E) by inserting after paragraph (3) the  
2 following new paragraph:

3 “(4) LIMITED PROCESS FOR ADDITIONAL  
4 MULTI-STAKEHOLDER INPUT.—In addition to the  
5 Secretary making measures publically available pur-  
6 suant to the dates described in paragraph (2) and  
7 multi-stakeholder groups transmitting the input pur-  
8 suant to the applicable dates described in paragraph  
9 (3)—

10 “(A) the Secretary may, at times that do  
11 not meet the time requirements described in  
12 paragraph (2), make available to the public a  
13 limited number of quality and efficiency meas-  
14 ures described in section 1890A(b)(2) that the  
15 Secretary is considering under this title; and

16 “(B) if the Secretary uses the authority  
17 under subparagraph (A), the entity with a con-  
18 tract under section 1890A shall, pursuant to  
19 section 1890A(b)(3), transmit to the Secretary  
20 on a timely basis the input from a multi-stake-  
21 holder group described in paragraph (1) with  
22 respect to such measures.”;

23 (F) in paragraph (6), as redesignated by  
24 subparagraph (D)(ii), by inserting “or that has  
25 not been recommended by the multi-stakeholder

1 group under section 1890A(b)(2)” before the  
 2 period at the end; and

3 (G) by inserting after paragraph (6) the  
 4 following new paragraph:

5 “(7) CONCORDANCE RATES.—For each year  
 6 (beginning with 2015), the Secretary shall include a  
 7 list of concordance rates with respect to the input  
 8 provided under section 1890A(b)(2)(A) for those  
 9 new measures adopted for each type of provider of  
 10 services and supplier in the annual final rule appli-  
 11 cable to such type of provider or supplier.”.

12 (2) REVIEW.—Section 1890B(c) of the Social  
 13 Security Act (42 U.S.C. 1395aaa–1(c)), as redesign-  
 14 nated by subsection (a)(1)(A), is amended—

15 (A) in paragraph (1)(A), by striking “sec-  
 16 tion 1890(b)(7)(B)” and inserting “section  
 17 1890A(b)(2)(B)”; and

18 (B) in paragraph (2)—

19 (i) in subparagraph (A), by striking  
 20 “and” at the end;

21 (ii) in subparagraph (B), by striking  
 22 the period at the end and inserting “;  
 23 and”; and

24 (iii) by adding at the end the fol-  
 25 lowing new subparagraph:



1           “(C) take into consideration the benefits of  
2           the alignment of measures between the public  
3           and private sector.”.

4           (d) FUNDING FOR QUALITY MEASURE ENDORSE-  
5   MENT, INPUT, AND SELECTION.—

6           (1) FISCAL YEAR 2014.—In addition to amounts  
7           transferred under section 3014(c) of the Patient  
8           Protection and Affordable Care Act (Public Law  
9           111–148), for purposes of carrying out section 1890  
10          and section 1890A (other than subsections (e) and  
11          (f)), the Secretary shall provide for the transfer,  
12          from the Federal Hospital Insurance Trust Fund  
13          under section 1817 and the Federal Supplementary  
14          Medical Insurance Trust Fund under section 1841,  
15          in such proportion as the Secretary determines ap-  
16          propriate, to the Centers for Medicare & Medicaid  
17          Services Program Management Account of  
18          \$7,000,000 for fiscal year 2014. Amounts trans-  
19          ferred under the preceding sentence shall remain  
20          available until expended.

21          (2) FISCAL YEARS 2015 THROUGH 2017.—Sec-  
22          tion 1890B of the Social Security Act (42 U.S.C.  
23          1395aaa–1), as redesignated by subsection  
24          (a)(1)(A), is amended by adding at the end the fol-  
25          lowing new subsection:

1 “(g) FUNDING.—

2 “(1) IN GENERAL.—For purposes of carrying  
3 out this section (other than subsections (e) and (f))  
4 and sections 1890 and 1890A, the Secretary shall  
5 provide for the transfer, from the Federal Hospital  
6 Insurance Trust Fund under section 1817 and the  
7 Federal Supplementary Medical Insurance Trust  
8 Fund under section 1841, in such proportion as the  
9 Secretary determines appropriate, to the Centers for  
10 Medicare & Medicaid Services Program Management  
11 Account of \$25,000,000 for each of fiscal years  
12 2015 through 2017.

13 “(2) AVAILABILITY.—Amounts transferred  
14 under paragraph (1) shall remain available until ex-  
15 pended.”.

16 (3) CONFORMING AMENDMENT.—Subsection (d)  
17 of section 1890 of the Social Security Act (42  
18 U.S.C. 1395aaa) is repealed.

19 (e) CONFORMING AMENDMENTS.—(1) Section  
20 1848(m)(3)(E)(iii) of the Social Security Act (42 U.S.C.  
21 1395w–4(m)(3)(E)(iii)) is amended by striking “section  
22 1890(b)(7) and 1890A(a)” and inserting “section  
23 1890A(b)(2) and 1890B(a)”.

24 (2) Section 1866D(b)(2)(C) of the Social Security  
25 Act (42 U.S.C. 1395cc–4(b)(2)(C)) is amended by striking

1 “section 1890 and 1890A” and inserting “sections 1890,  
2 1890A, and 1890B”.

3 (3) Section 1899A(n)(2)(A) of the Social Security  
4 Act (42 U.S.C. 1395cc–4(n)(2)(A)) is amended by strik-  
5 ing “section 1890(b)(7)(B)” and inserting “section  
6 1890A(b)(2)(B)”.

7 (f) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The amendments made by  
9 this section shall take effect on October 1, 2014,  
10 and shall apply with respect to contract periods  
11 under sections 1890 and 1890A of the Social Secu-  
12 rity Act that begin on or after such date.

13 (2) NEW CONTRACTS.—The Secretary of  
14 Health and Human Services shall enter into a new  
15 contract under both sections 1890 and 1890A of the  
16 Social Security Act, as amended by this Act, for a  
17 contract period beginning on, or as soon as prac-  
18 ticable after, October 1, 2014.

19 **SEC. 209. PERMANENT EXTENSION OF FUNDING OUTREACH**  
20 **AND ASSISTANCE FOR LOW-INCOME PRO-**  
21 **GRAMS.**

22 (a) ADDITIONAL FUNDING FOR STATE HEALTH IN-  
23 SURANCE PROGRAMS.—Subsection (a)(1)(B)(iv) of section  
24 119 of the Medicare Improvements for Patients and Pro-  
25 viders Act of 2008 (42 U.S.C. 1395b–3 note), as amended

1 by section 3306 of the Patient Protection and Affordable  
 2 Care Act (Public Law 111–148), section 610 of the Amer-  
 3 ican Taxpayer Relief Act of 2012 (Public Law 112–240),  
 4 and section 1110 of the Pathway for SGR Reform Act  
 5 of 2013 (Public Law 113–67), is amended to read as fol-  
 6 lows:

7 “(iv) for fiscal year 2014 and for each  
 8 subsequent fiscal year, \$7,500,000.”.

9 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON  
 10 AGING.—Subsection (b)(1)(B)(iv) of such section 119, as  
 11 so amended, is amended to read as follows:

12 “(iv) for fiscal year 2014 and for each  
 13 subsequent fiscal year, \$7,500,000.”.

14 (c) ADDITIONAL FUNDING FOR AGING AND DIS-  
 15 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B)(iv)  
 16 of such section 119, as so amended, is amended to read  
 17 as follows:

18 “(iv) for fiscal year 2014 and for each  
 19 subsequent fiscal year, \$5,000,000.”.

20 (d) ADDITIONAL FUNDING FOR CONTRACT WITH  
 21 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH  
 22 ENROLLMENT.—Subsection (d)(2)(iv) of such section 119,  
 23 as so amended, is amended to read as follows:

24 “(iv) for fiscal year 2014 and for each  
 25 subsequent fiscal year, \$5,000,000.”.

## 1      **Subtitle B—Medicaid and Other** 2                                    **Extensions**

### 3      **SEC. 211. QUALIFYING INDIVIDUAL PROGRAM.**

4            (a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the  
5      Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is  
6      amended by striking “March 2104” and inserting “De-  
7      cember 2018”.

8            (b) ELIMINATING LIMITATIONS ON ELIGIBILITY.—  
9      Section 1933 of the Social Security Act (42 U.S.C.  
10     1396u–3) is amended by striking subsections (b) and (e).

11          (c) ELIMINATING ALLOCATIONS.—Section 1933 of  
12     the Social Security Act (42 U.S.C. 1396u–3) is amended  
13     by striking subsections (c) and (g).

14          (d) CONFORMING AMENDMENTS.—

15            (1) IN GENERAL.—Section 1933 of the Social  
16     Security Act (42 U.S.C. 1396u–3), as amended by  
17     subsections (b) and (c), is further amended—

18                    (A) by striking subsection (a) and insert-  
19                    ing the following new subsection:

20            “(a) APPLICABLE FMAP.—With respect to assist-  
21     ance described in section 1902(a)(10)(E)(iv) furnished in  
22     a State, the Federal medical assistance percentage shall  
23     be equal to 100 percent.”;

24                    (B) by striking subsection (d); and

1 (C) by redesignating subsection (f) as sub-  
2 section (b).

3 (2) DEFINITION OF FMAP.—Section 1905(b) of  
4 the Social Security Act (42 U.S.C. 1396d(b)) is  
5 amended by striking “section 1933(d)” and insert-  
6 ing “section 1933(a)”.

7 (e) EFFECTIVE DATE.—The amendments made by  
8 this section shall take effect on April 1, 2014, and shall  
9 apply with respect to calendar quarters beginning on or  
10 after such date.

11 **SEC. 212. TRANSITIONAL MEDICAL ASSISTANCE.**

12 (a) EXTENSION.—Sections 1902(e)(1)(B) and  
13 1925(f) of the Social Security Act (42 U.S.C.  
14 1396a(e)(1)(B), 1396r–6(f)) are each amended by strik-  
15 ing “March 31, 2014” and inserting “December 31,  
16 2018”.

17 (b) OPT-OUT OPTION FOR STATES THAT EXPAND  
18 ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS  
19 ELIGIBILITY UNDER MEDICAID AND CHIP.—

20 (1) IN GENERAL.—Section 1925 of the Social  
21 Security Act (42 U.S.C. 1396r–6), as amended by  
22 subsection (a), is further amended—

23 (A) in subsection (a)—

1 (i) in paragraph (1)(A), by striking  
 2 “paragraph (5)” and inserting “para-  
 3 graphs (5) and (6)”; and

4 (ii) by adding at the end the fol-  
 5 lowing:

6 “(6) OPT-OUT OPTION FOR STATES THAT EX-  
 7 PAND ADULT COVERAGE AND PROVIDE 12-MONTH  
 8 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND  
 9 CHIP.—

10 “(A) IN GENERAL.—In the case of a State  
 11 described in subparagraph (B), the State may  
 12 elect through a State plan amendment to have  
 13 this section and sections 408(a)(11)(A),  
 14 1902(a)(52), 1902(e)(1), and 1931(c)(2) not  
 15 apply to the State.

16 “(B) STATE DESCRIBED.—A State is de-  
 17 scribed in this subparagraph if the State is one  
 18 of the 50 States or the District of Columbia  
 19 and—

20 “(i) has elected to provide medical as-  
 21 sistance to individuals under subclause  
 22 (VIII) of section 1902(a)(10)(A)(i);

23 “(ii) has elected under section  
 24 1902(e)(12)(A) the option to provide con-

1           tinuous eligibility for a 12-month period  
2           for individuals under 19 years of age;

3           “(iii) has elected under section  
4           1902(e)(12)(B) the option to provide con-  
5           tinuous eligibility for a 12-month period  
6           for all categories of individuals described in  
7           that section; and

8           “(iv) has elected to apply section  
9           1902(e)(12)(A) to the State child health  
10          plan under title XXI.”; and

11          (B) in subsection (b)(1), by striking “sub-  
12          section (a)(5)” and inserting “paragraphs (5)  
13          and (6) of subsection (a)”.

14          (2) CONFORMING AMENDMENT TO 4-MONTH RE-  
15          QUIREMENT.—Section 1902(e)(1) of the Social Se-  
16          curity Act (42 U.S.C. 1396a(e)(1)), as amended by  
17          subsection (a), is further amended—

18               (A) in subparagraph (B), by striking  
19               “Subparagraph (A)” and inserting “Subject to  
20               subparagraph (C), subparagraph (A)”;

21               (B) by adding at the end the following:

22               “(C) If a State has made an election under section  
23          1925(a)(6), subparagraph (A) and section 1925 shall not  
24          apply to the State.”.



1 (c) EXTENSION OF 12-MONTH CONTINUOUS ELIGI-  
 2 BILITY OPTION TO CERTAIN ADULT ENROLLEES UNDER  
 3 MEDICAID; CLARIFICATION OF APPLICATION TO CHIP.—

4 (1) IN GENERAL.—Section 1902(e)(12) of the  
 5 Social Security Act (42 U.S.C. 1396a(e)(12)) is  
 6 amended—

7 (A) by redesignating subparagraphs (A)  
 8 and (B) as clauses (i) and (ii), respectively;

9 (B) by inserting “(A)” after “(12)”; and

10 (C) by adding at the end the following:

11 “(B) At the option of the State, the plan may provide  
 12 that an individual who is determined to be eligible for ben-  
 13 efits under a State plan approved under this title under  
 14 any of the following eligibility categories, or who is rede-  
 15 termined to be eligible for such benefits under any of such  
 16 categories, shall be considered to meet the eligibility re-  
 17 quirements met on the date of application and shall re-  
 18 main eligible for those benefits until the end of the 12-  
 19 month period following the date of the determination or  
 20 redetermination of eligibility:

21 “(i) Section 1902(a)(10)(A)(i)(VIII).

22 “(ii) Section 1931.”.

23 (2) APPLICATION TO CHIP.—Section 2107(e)(1)  
 24 of the Social Security Act (42 U.S.C. 1397gg(e)(1))  
 25 is amended—

1 (A) by redesignating subparagraphs (E)  
 2 through (O) as subparagraphs (F) through (P),  
 3 respectively; and

4 (B) by inserting after subparagraph (D),  
 5 the following:

6 “(E) Section 1902(e)(12)(A) (relating to  
 7 the State option for 12-month continuous eligi-  
 8 bility and enrollment).”.

9 (d) CONFORMING AND TECHNICAL AMENDMENTS  
 10 RELATING TO SECTION 1931 TRANSITIONAL COVERAGE  
 11 REQUIREMENTS.—

12 (1) IN GENERAL.—Section 1931(c) of the So-  
 13 cial Security Act (42 U.S.C. 1396u–1(c)) is amend-  
 14 ed—

15 (A) in paragraph (1)—

16 (i) in the paragraph heading, by strik-  
 17 ing “CHILD” and inserting “SPOUSAL”;

18 (ii) by striking “The provisions” and  
 19 inserting “Subject to paragraph (3), the  
 20 provisions”; and

21 (iii) by striking “child or”;

22 (B) in paragraph (2), by striking “For  
 23 continued” and inserting “Subject to paragraph  
 24 (3), for continued”; and

25 (C) by adding at the end the following:

1           “(3) OPT-OUT OPTION FOR STATES THAT EX-  
2           PAND ADULT COVERAGE AND PROVIDE 12-MONTH  
3           CONTINUOUS ELIGIBILITY UNDER MEDICAID AND  
4           CHIP.—

5           “(A) IN GENERAL.—In the case of a State  
6           described in subparagraph (B), the State may  
7           elect through a State plan amendment to have  
8           paragraphs (1) and (2) of this subsection and  
9           sections 408(a)(11), 1902(a)(52), 1902(e)(1),  
10          and 1925 not apply to the State.

11          “(B) STATE DESCRIBED.—A State is de-  
12          scribed in this subparagraph if the State is one  
13          of the 50 States or the District of Columbia  
14          and—

15               “(i) has elected to provide medical as-  
16               sistance to individuals under subclause  
17               (VIII) of section 1902(a)(10)(A)(i);

18               “(ii) has elected under section  
19               1902(e)(12)(A) the option to provide con-  
20               tinuous eligibility for a 12-month period  
21               for individuals under 19 years of age;

22               “(iii) has elected under section  
23               1902(e)(12)(B) the option to provide con-  
24               tinuous eligibility for a 12-month period

1 for all categories of individuals described in  
2 that section; and

3 “(iv) has elected to apply section  
4 1902(e)(12)(A) to the State child health  
5 plan under title XXI.”.

6 (2) CONFORMING AMENDMENT TO SECTION  
7 408.—Section 408(a)(11) of the Social Security Act  
8 (42 U.S.C. 608(a)(11) is amended—

9 (A) in the paragraph heading, by striking  
10 “CHILD” and inserting “SPOUSAL”; and

11 (B) in subparagraph (B)—

12 (i) in the subparagraph heading, by  
13 striking “CHILD” and inserting “SPOUS-  
14 AL”; and

15 (ii) by striking “child or”.

16 (e) CONFORMING AMENDMENT RELATING TO MAIN-  
17 TENANCE OF EFFORT FOR CHILDREN.—Section  
18 1902(gg)(4) of the Social Security Act (42 U.S.C.  
19 1396a(gg)(4)) is amended by adding at the end the fol-  
20 lowing:

21 “(C) STATES THAT EXPAND ADULT COV-  
22 ERAGE AND ELECT TO OPT-OUT OF TRANSI-  
23 TIONAL COVERAGE.—

24 “(i) IN GENERAL.—For purposes of  
25 determining compliance with the require-

1           ments of paragraph (2), a State which ex-  
2           ercises the option under sections  
3           1925(a)(6) and 1931(c)(3) to provide no  
4           transitional medical assistance or other ex-  
5           tended eligibility (as applicable) shall not,  
6           as a result of exercising such option, be  
7           considered to have in effect eligibility  
8           standards, methodologies, or procedures  
9           described in clause (ii) that are more re-  
10          strictive than the standards, methodolo-  
11          gies, or procedures in effect under the  
12          State plan or under a waiver of the plan  
13          on the date of enactment of the Patient  
14          Protection and Affordable Care Act.

15               “(ii) STANDARDS, METHODOLOGIES,  
16               OR PROCEDURES DESCRIBED.—The eligi-  
17               bility standards, methodologies, or proce-  
18               dures described in this clause are those  
19               standards, methodologies, or procedures  
20               applicable to determining the eligibility for  
21               medical assistance of any child under 19  
22               years of age (or such higher age as the  
23               State may have elected).”.

24           (f) EFFECTIVE DATE.—The amendments made by  
25   this section shall take effect on April 1, 2014.

1 **SEC. 213. EXPRESS LANE ELIGIBILITY.**

2 Section 1902(e)(13)(I) of the Social Security Act (42  
3 U.S.C. 1396a(e)(13)(I)) is amended by striking “Sep-  
4 tember 30, 2014” and inserting “September 30, 2015”.

5 **SEC. 214. PEDIATRIC QUALITY MEASURES.**

6 (a) CONTINUATION OF FUNDING FOR PEDIATRIC  
7 QUALITY MEASURES FOR IMPROVING THE QUALITY OF  
8 CHILDREN’S HEALTH CARE.—Section 1139B(e) of the  
9 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended  
10 by adding at the end the following: “Of the funds appro-  
11 priated under this subsection, not less than \$15,000,000  
12 shall be used to carry out section 1139A(b).”.

13 (b) ELIMINATION OF RESTRICTION ON MEDICAID  
14 QUALITY MEASUREMENT PROGRAM.—Section  
15 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.  
16 1320b–9b(b)(5)(A)) is amended by striking “The aggre-  
17 gate amount awarded by the Secretary for grants and con-  
18 tracts for the development, testing, and validation of  
19 emerging and innovative evidence-based measures under  
20 such program shall equal the aggregate amount awarded  
21 by the Secretary for grants under section  
22 1139A(b)(4)(A)”.

23 **SEC. 215. SPECIAL DIABETES PROGRAMS.**

24 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-  
25 BETES.—Section 330B(b)(2)(C) of the Public Health

1 Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by  
 2 striking “2014” and inserting “2019”.

3 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
 4 Section 330C(c)(2)(C) of the Public Health Service Act  
 5 (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking  
 6 “2014” and inserting “2019”.

## 7 **Subtitle C—Human Services** 8 **Extensions**

### 9 **SEC. 221. ABSTINENCE EDUCATION GRANTS.**

10 (a) IN GENERAL.—Section 510 of the Social Security  
 11 Act (42 U.S.C. 710) is amended—

12 (1) in subsection (a), in the matter preceding  
 13 paragraph (1), by striking “2010 through 2014”  
 14 and inserting “2015 through 2019”; and

15 (2) in subsection (d)—

16 (A) by striking “2010 through 2014” and  
 17 inserting “2015 through 2019”; and

18 (B) by striking the second sentence.

19 (b) EFFECTIVE DATE.—The amendments made by  
 20 this section shall take effect on October 1, 2014.

### 21 **SEC. 222. PERSONAL RESPONSIBILITY EDUCATION PRO-** 22 **GRAM.**

23 (a) IN GENERAL.—Section 513 of the Social Security  
 24 Act (42 U.S.C. 713) is amended—

25 (1) in subsection (a)—

1 (A) in paragraph (1)(A), by striking “2010  
2 through 2014” and inserting “2015 through  
3 2019”;

4 (B) in paragraph (4)—

5 (i) in subparagraph (A)—

6 (I) by striking “2010 or 2011”  
7 and inserting “2015 or 2016”;

8 (II) by striking “2010 through  
9 2014” and inserting “2015 through  
10 2019”; and

11 (III) by striking “2012 through  
12 2014” and inserting “2017 through  
13 2019”; and

14 (ii) in subparagraph (B)(i)—

15 (I) by striking “2012, 2013, and  
16 2014” and inserting “2017, 2018,  
17 and 2019”; and

18 (II) by striking “2010 or 2011”  
19 and inserting “2015 or 2016”; and

20 (C) in paragraph (5), by striking “2009”  
21 and inserting “2014”;

22 (2) in subsection (b)(2)(A), in the matter pre-  
23 ceding clause (i), by inserting “and youth at risk of  
24 becoming victims of sex trafficking (as defined in  
25 section 103(10) of the Trafficking Victims Protec-



tion 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).

1 (b) PREVENTION OF DUPLICATE APPROPRIATIONS  
 2 FOR FISCAL YEAR 2014.—Expenditures made for fiscal  
 3 year 2014 pursuant to section 501(c)(iv) of the Social Se-  
 4 curity Act (42 U.S.C. 701(c)(iv)), as amended by section  
 5 1203 of division B of the Bipartisan Budget Act of 2013  
 6 (Public Law 113–67), shall be charged to the appropria-  
 7 tion for that fiscal year provided by the amendments made  
 8 by this section.

9 **SEC. 224. HEALTH WORKFORCE DEMONSTRATION PROJECT**  
 10 **FOR LOW-INCOME INDIVIDUALS.**

11 Section 2008(c)(1) of the Social Security Act (42  
 12 U.S.C. 1397g(c)(1)) is amended by striking “ through  
 13 2014” and inserting “2012, and only to carry out sub-  
 14 section (a), \$85,000,000 for each of fiscal years 2013  
 15 through 2016”.

16 **TITLE III—MEDICARE AND**  
 17 **MEDICAID PROGRAM INTEGRITY**

18 **SEC. 301. REDUCING IMPROPER MEDICARE PAYMENTS.**

19 (a) MEDICARE ADMINISTRATIVE CONTRACTOR IM-  
 20 PROPER PAYMENT OUTREACH AND EDUCATION PRO-  
 21 GRAM.—

22 (1) IN GENERAL.—Section 1874A of the Social  
 23 Security Act (42 U.S.C. 1395kk–1) is amended—

24 (A) in subsection (a)(4)—

1 (i) by redesignating subparagraph (G)  
2 as subparagraph (H); and

3 (ii) by inserting after subparagraph  
4 (F) the following new subparagraph:

5 “(G) IMPROPER PAYMENT OUTREACH AND  
6 EDUCATION PROGRAM.—Having in place an im-  
7 proper payment outreach and education pro-  
8 gram described in subsection (h).”; and

9 (B) by adding at the end the following new  
10 subsection:

11 “(h) IMPROPER PAYMENT OUTREACH AND EDU-  
12 CATION PROGRAM.—

13 “(1) IN GENERAL.—In order to reduce im-  
14 proper payments under this title, each medicare ad-  
15 ministrative contractor shall establish and have in  
16 place an improper payment outreach and education  
17 program under which the contractor, through out-  
18 reach, education, training, and technical assistance  
19 activities, shall provide providers of services and sup-  
20 pliers located in the region covered by the contract  
21 under this section with the information described in  
22 paragraph (3). The activities described in the pre-  
23 ceding sentence shall be conducted on a regular  
24 basis.

1           “(2) FORMS OF OUTREACH, EDUCATION, TRAIN-  
2           ING, AND TECHNICAL ASSISTANCE ACTIVITIES.—The  
3           outreach, education, training, and technical assist-  
4           ance activities under a payment outreach and edu-  
5           cation program shall be carried out through any of  
6           the following:

7                   “(A) Emails and other electronic commu-  
8                   nications.

9                   “(B) Webinars.

10                  “(C) Telephone calls.

11                  “(D) In-person training.

12                  “(E) Other forms of communications de-  
13                  termined appropriate by the Secretary.

14           “(3) INFORMATION TO BE PROVIDED THROUGH  
15           ACTIVITIES.—The information to be provided to pro-  
16           viders of services and suppliers under a payment  
17           outreach and education program shall include all of  
18           the following information:

19                   “(A) A list of the provider’s or supplier’s  
20                   most frequent and expensive payment errors  
21                   over the last quarter.

22                   “(B) Specific instructions regarding how to  
23                   correct or avoid such errors in the future.

24                   “(C) A notice of all new topics that have  
25                   been approved by the Secretary for audits con-

1           ducted by recovery audit contractors under sec-  
2           tion 1893(h).

3           “(D) Specific instructions to prevent fu-  
4           ture issues related to such new audits.

5           “(E) Other information determined appro-  
6           priate by the Secretary.

7           “(4) ERROR RATE REDUCTION TRAINING.—

8           “(A) IN GENERAL.—The activities under a  
9           payment outreach and education program shall  
10          include error rate reduction training.

11          “(B) REQUIREMENTS.—

12          “(i) IN GENERAL.—The training de-  
13          scribed in subparagraph (A) shall—

14                  “(I) be provided at least annu-  
15                  ally; and

16                  “(II) focus on reducing the im-  
17                  proper payments described in para-  
18                  graph (5).

19          “(C) INVITATION.—A medicare adminis-  
20          trative contractor shall ensure that all providers  
21          of services and suppliers located in the region  
22          covered by the contract under this section are  
23          invited to attend the training described in sub-  
24          paragraph (A) either in person or online.

1           “(5) PRIORITY.—A medicare administrative  
 2 contractor shall give priority to activities under the  
 3 improper payment outreach and education program  
 4 that will reduce improper payments for items and  
 5 services that—

6           “(A) have the highest rate of improper  
 7 payment;

8           “(B) have the greatest total dollar amount  
 9 of improper payments;

10           “(C) are due to clear misapplication or  
 11 misinterpretation of Medicare policies;

12           “(D) are clearly due to common and inad-  
 13 vertent clerical or administrative errors; or

14           “(E) are due to other types of errors that  
 15 the Secretary determines could be prevented  
 16 through activities under the program.

17           “(6) INFORMATION ON IMPROPER PAYMENTS  
 18 FROM RECOVERY AUDIT CONTRACTORS.—

19           “(A) IN GENERAL.—In order to assist  
 20 medicare administrative contractors in carrying  
 21 out improper payment outreach and education  
 22 programs, the Secretary shall provide each con-  
 23 tractor with a complete list of improper pay-  
 24 ments identified by recovery audit contractors  
 25 under section 1893(h) with respect to providers

1 of services and suppliers located in the region  
2 covered by the contract under this section. Such  
3 information shall be provided on a quarterly  
4 basis.

5 “(B) INFORMATION.—The information de-  
6 scribed in subparagraph (A) shall include the  
7 following information:

8 “(i) The providers of services and  
9 suppliers that have the highest rate of im-  
10 proper payments.

11 “(ii) The providers of services and  
12 suppliers that have the greatest total dollar  
13 amounts of improper payments.

14 “(iii) The items and services furnished  
15 in the region that have the highest rates of  
16 improper payments.

17 “(iv) The items and services furnished  
18 in the region that are responsible for the  
19 greatest total dollar amount of improper  
20 payments.

21 “(v) Other information the Secretary  
22 determines would assist the contractor in  
23 carrying out the improper payment out-  
24 reach and education program.

1           “(C) FORMAT OF INFORMATION.—The in-  
 2           formation furnished to medicare administrative  
 3           contractors by the Secretary under this para-  
 4           graph shall be transmitted in a manner that  
 5           permits the contractor to easily identify the  
 6           areas of the Medicare program in which tar-  
 7           geted outreach, education, training, and tech-  
 8           nical assistance would be most effective. In car-  
 9           rying out the preceding sentence, the Secretary  
 10          shall ensure that—

11                   “(i) the information with respect to  
 12                   improper payments made to a provider of  
 13                   services or supplier clearly displays the  
 14                   name and address of the provider or sup-  
 15                   plier, the amount of the improper payment,  
 16                   and any other information the Secretary  
 17                   determines appropriate; and

18                   “(ii) the information is in an elec-  
 19                   tronic, easily searchable database.

20          “(7) COMMUNICATIONS.—All communications  
 21          with providers of services and suppliers under a pay-  
 22          ment outreach and education program are subject to  
 23          the standards and requirements of subsection (g).

24          “(8) FUNDING.—After application of paragraph  
 25          (1)(C) of section 1893(h), the Secretary shall retain



1 a portion of the amounts recovered by recovery audit  
 2 contractors under such section which shall be avail-  
 3 able to the program management account of the  
 4 Centers for Medicare & Medicaid Services for pur-  
 5 poses of carrying out this subsection and to imple-  
 6 ment corrective actions to help reduce the error rate  
 7 of payments under this title. The amount retained  
 8 under the preceding sentence shall not exceed an  
 9 amount equal to 25 percent of the amounts recov-  
 10 ered under section 1893(h).”.

11 (2) FUNDING CONFORMING AMENDMENT.—Sec-  
 12 tion 1893(h)(2) of the Social Security Act (42  
 13 U.S.C. 1395ddd(h)(2)) is amended by inserting “or  
 14 section 1874(h)(8)” after “paragraph (1)(C)”.

15 (3) EFFECTIVE DATE.—The amendments made  
 16 by this subsection take effect on January 1, 2015.

17 (b) TRANSPARENCY.—Section 1893(h)(8) of the So-  
 18 cial Security Act (42 U.S.C. 1395ddd(h)(8)) is amended—

19 (1) by striking “REPORT.—The Secretary” and  
 20 inserting “REPORT.—

21 “(A) IN GENERAL.—The Secretary”; and

22 (2) by adding at the end the following new sub-  
 23 paragraph:

24 “(B) INCLUSION OF CERTAIN INFORMA-  
 25 TION.—

“(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—

1 (A) targets audits by recovery audit con-  
2 tractors under section 1893(h) of the Social Se-  
3 curity Act (42 U.S.C. 1395ddd(h)) with respect  
4 to high error providers of services and suppliers  
5 identified under paragraph (3); and

6 (B) rewards low error providers of services  
7 and suppliers identified under such paragraph.

8 (2) SCOPE.—

9 (A) DURATION.—The demonstration  
10 project shall be implemented not later than  
11 January 1, 2015, and shall be conducted for a  
12 period of three years.

13 (B) DEMONSTRATION AREA.—In deter-  
14 mining the geographic area of the demonstra-  
15 tion project, the Secretary shall consider the  
16 following:

17 (i) The total number of providers of  
18 services and suppliers in the region.

19 (ii) The diversity of types of providers  
20 of services and suppliers in the region.

21 (iii) The level and variation of im-  
22 proper payment rates of and among indi-  
23 vidual providers of services and suppliers  
24 in the region.

1 (iv) The inclusion of a mix of both  
2 urban and rural areas.

3 (3) IDENTIFICATION OF LOW ERROR AND HIGH  
4 ERROR PROVIDERS OF SERVICES AND SUPPLIERS.—

5 (A) IN GENERAL.—In conducting the dem-  
6 onstration project, the Secretary shall identify  
7 the following two groups of providers in accord-  
8 ance with this paragraph:

9 (i) Low error providers of services and  
10 suppliers.

11 (ii) High error providers of services  
12 and suppliers.

13 (B) ANALYSIS.—For purposes of identi-  
14 fying the groups under subparagraph (A), the  
15 Secretary shall analyze the following as they re-  
16 late to the total number and amount of claims  
17 submitted in the area and by each provider:

18 (i) The improper payment rates of in-  
19 dividual providers of services and suppliers.

20 (ii) The amount of improper payments  
21 made to individual providers of services  
22 and suppliers.

23 (iii) The frequency of errors made by  
24 the provider of services or supplier over  
25 time.

1 (iv) Other information determined ap-  
2 propriate by the Secretary.

3 (C) ASSIGNMENT BASED ON COMPOSITE  
4 SCORE.—The Secretary shall assign selected  
5 providers of services and suppliers under the  
6 demonstration program based on a composite  
7 score determined using the analysis under sub-  
8 paragraph (B) as follows:

9 (i) Providers of services and suppliers  
10 with high, expensive, and frequent errors  
11 shall receive a high score and be identified  
12 as high error providers of services and sup-  
13 pliers under subparagraph (A).

14 (ii) Providers of services and suppliers  
15 with few, inexpensive, and infrequent er-  
16 rors shall receive a low score and be identi-  
17 fied as low error providers of services and  
18 suppliers under such subparagraph.

19 (iii) Only a small proportion of the  
20 total providers of services and suppliers  
21 and individual types of providers of serv-  
22 ices and suppliers in the geographic area  
23 of the demonstration project shall be as-  
24 signed to either group identified under  
25 such subparagraph.

1 (D) TIMEFRAME OF IDENTIFICATION.—

2 (i) IN GENERAL.—Any identification  
3 of a provider of services or a supplier  
4 under subparagraph (A) shall be for a pe-  
5 riod of 12 months.

6 (ii) REEVALUATION.—The Secretary  
7 shall reevaluate each such identification at  
8 the end of such period.

9 (iii) USE OF MOST CURRENT INFOR-  
10 MATION.—In carrying out the reevaluation  
11 under clause (ii) with respect to a provider  
12 of services or supplier, the Secretary  
13 shall—

14 (I) consider the most current in-  
15 formation available with respect to the  
16 provider of services or supplier under  
17 the analysis under subparagraph (B);  
18 and

19 (II) take into account improve-  
20 ment or regression of the provider of  
21 services or supplier.

22 (4) ADJUSTMENT OF RECORD REQUEST MAX-  
23 IMUM.—Under the demonstration project, the Sec-  
24 retary shall establish procedures to—

1 (A) increase the maximum record request  
2 made by recovery audit contractors to providers  
3 of services and suppliers identified as high error  
4 providers of services and suppliers under para-  
5 graph (3); and

6 (B) decrease the maximum record request  
7 made by recovery audit contractors to providers  
8 of services and suppliers identified as low error  
9 providers of services and supplier under such  
10 paragraph.

11 (5) ADDITIONAL ADJUSTMENTS.—

12 (A) IN GENERAL.—Under the demonstra-  
13 tion project, the Secretary may make additional  
14 adjustments to requirements for recovery audit  
15 contractors under section 1893(h) of the Social  
16 Security Act (42 U.S.C. 1395ddd(h)) and the  
17 conduct of audits with respect to low error pro-  
18 viders of services and suppliers identified under  
19 paragraph (3) and high error providers of serv-  
20 ices and suppliers identified under such para-  
21 graph as the Secretary determines necessary in  
22 order to incentivize reductions in improper pay-  
23 ment rates under title XVIII of such Act (42  
24 U.S.C. 1395 et seq.).

1 (B) LIMITATION.—The Secretary shall not  
 2 exempt any group of providers of services or  
 3 suppliers in the demonstration project from  
 4 being subject to audit by a recovery audit con-  
 5 tractor under such section 1893(h).

6 (6) EVALUATION AND REPORT.—

7 (A) EVALUATION.—The Inspector General  
 8 of the Department of Health and Human Serv-  
 9 ices shall conduct an evaluation of the dem-  
 10 onstration project under this subsection. The  
 11 evaluation shall include an analysis of—

12 (i) the error rates of providers of serv-  
 13 ices and suppliers—

14 (I) identified under paragraph  
 15 (3) as low error providers of services  
 16 and suppliers;

17 (II) identified under such para-  
 18 graph as high error providers of serv-  
 19 ices and suppliers; and

20 (III) that are located in the geo-  
 21 graphic area of the demonstration  
 22 project and are not identified as either  
 23 a low error or high error provider of  
 24 services or supplier under such para-  
 25 graph; and



1                   (ii) any improvements in the error  
2                   rates of those high error providers of serv-  
3                   ices and suppliers identified under such  
4                   paragraph.

5                   (B) REPORT.—Not later than 12 months  
6                   after completion of the demonstration project,  
7                   the Inspector General shall submit to Congress  
8                   a report containing the results of the evaluation  
9                   conducted under subparagraph (A), together  
10                  with recommendations on whether the dem-  
11                  onstration project should be continued or ex-  
12                  panded, including on a permanent or nation-  
13                  wide basis.

14               (7) FUNDING.—

15               (A) FUNDING FOR IMPLEMENTATION.—  
16               For purposes of carrying out the demonstration  
17               project under this subsection (other than the  
18               evaluation and report under paragraph (6)), the  
19               Secretary shall provide for the transfer, from  
20               the Federal Hospital Insurance Trust Fund  
21               under section 1817 (42 U.S.C. 1395i) and the  
22               Federal Supplementary Medical Insurance  
23               Trust Fund under section 1841 (42 U.S.C.  
24               1395t), in such proportion as the Secretary de-  
25               termines 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 en-

1           tity with a contract under section 1893(h) of  
 2           the Social Security Act (42 U.S.C.  
 3           1395ddd(h)).

4           (D) SECRETARY.—The term “Secretary”  
 5           means the Secretary of Health and Human  
 6           Services.

7           (E) SUPPLIER.—The term “supplier” has  
 8           the meaning given that term in section 1861(d).

9   **SEC. 302. AUTHORITY FOR MEDICAID FRAUD CONTROL**  
 10           **UNITS TO INVESTIGATE AND PROSECUTE**  
 11           **COMPLAINTS OF ABUSE AND NEGLECT OF**  
 12           **MEDICAID PATIENTS IN HOME AND COMMU-**  
 13           **NITY-BASED SETTINGS.**

14       (a) IN GENERAL.—Section 1903(q)(4)(A) of the So-  
 15       cial Security Act (42 U.S.C. 1396b(q)(4)(A)) is amended  
 16       to read as follows:

17           “(4)(A) The entity’s function includes a state-  
 18       wide program for the—

19           “(i) investigation and prosecution, or refer-  
 20       ral for prosecution or other action, of com-  
 21       plaints of abuse or neglect of patients in health  
 22       care facilities which receive payments under the  
 23       State plan under this title or under a waiver of  
 24       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           “(1) COLLECTIONS FROM MEDICARE AND MED-  
2       ICAID RECOVERY ACTIONS.—Notwithstanding section  
3       3302 of title 31, United States Code, or any other  
4       provision of law affecting the crediting of collections,  
5       the Inspector General of the Department of Health  
6       and Human Services may receive and retain for cur-  
7       rent use three percent of all amounts collected pur-  
8       suant to civil debt collection and administrative en-  
9       forcement actions related to false claims or frauds  
10      involving the Medicare program under title XVIII or  
11      the Medicaid program under title XIX.

12           “(2) CREDITING.—Funds received by the In-  
13      spector General under paragraph (1) shall be depos-  
14      ited as offsetting collections to the credit of any ap-  
15      propriation available for oversight and enforcement  
16      activities of the Inspector General permitted under  
17      subsection (a), and shall remain available until ex-  
18      pended.”.

19           (b) EFFECTIVE DATE.—The amendment made by  
20      subsection (a) shall apply to funds received from settle-  
21      ments finalized, judgments entered, or final agency deci-  
22      sions issued, on or after the date of the enactment of this  
23      Act.

1 **SEC. 304. PREVENTING AND REDUCING IMPROPER MEDI-**  
2 **CARE AND MEDICAID EXPENDITURES.**

3 (a) **REQUIRING VALID PRESCRIBER NATIONAL PRO-**  
4 **VIDER IDENTIFIERS ON PHARMACY CLAIMS.**—Section  
5 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–  
6 104(c)) is amended by adding at the end the following new  
7 paragraph:

8 “(4) **REQUIRING VALID PRESCRIBER NATIONAL**  
9 **PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.**—

10 “(A) **IN GENERAL.**—For plan year 2015  
11 and subsequent plan years, subject to subpara-  
12 graph (B), the Secretary shall prohibit PDP  
13 sponsors of prescription drug plans from paying  
14 claims for prescription drugs under this part  
15 that do not include a valid prescriber National  
16 Provider Identifier.

17 “(B) **PROCEDURES.**—The Secretary shall  
18 establish procedures for determining the validity  
19 of prescriber National Provider Identifiers  
20 under subparagraph (A).

21 “(C) **REPORT.**—Not later than January 1,  
22 2017, the Inspector General of the Department  
23 of Health and Human Services shall submit to  
24 Congress a report on the effectiveness of the  
25 procedures established under subparagraph  
26 (B).”.

1 (b) REFORMING HOW CMS TRACKS AND CORRECTS  
2 THE VULNERABILITIES IDENTIFIED BY RECOVERY AUDIT  
3 CONTRACTORS.—Section 1893(h) of the Social Security  
4 Act (42 U.S.C. 1395ddd(h)) is amended—

5 (1) in paragraph (8), as amended by section  
6 301, by adding at the end the following new sub-  
7 paragraphs:

8 “(C) INCLUSION OF IMPROPER PAYMENT  
9 VULNERABILITIES IDENTIFIED.—For reports  
10 submitted under this paragraph for 2015 or a  
11 subsequent year, each such report shall in-  
12 clude—

13 “(i) a description of—

14 “(I) the types and financial cost  
15 to the program under this title of im-  
16 proper payment vulnerabilities identi-  
17 fied by recovery audit contractors  
18 under this subsection; and

19 “(II) how the Secretary is ad-  
20 dressing such improper payment  
21 vulnerabilities; and

22 “(ii) an assessment of the effective-  
23 ness of changes made to payment policies  
24 and procedures under this title in order to  
25 address the vulnerabilities so identified.

1           “(D) LIMITATION.—The Secretary shall  
 2           ensure that each report submitted under sub-  
 3           paragraph (A) does not include information  
 4           that the Secretary determines would be sen-  
 5           sitive or would otherwise negatively impact pro-  
 6           gram integrity.”; and

7           (2) by adding at the end the following new  
 8           paragraph:

9           “(10) ADDRESSING IMPROPER PAYMENT  
 10          VULNERABILITIES.—The Secretary shall address im-  
 11          proper payment vulnerabilities identified by recovery  
 12          audit contractors under this subsection in a timely  
 13          manner, prioritized based on the risk to the program  
 14          under this title.”.

15          (c) STRENGTHENING MEDICAID PROGRAM INTEG-  
 16          RITY THROUGH FLEXIBILITY.—Section 1936 of the Social  
 17          Security Act (42 U.S.C. 1396u–6) is amended—

18                 (1) in subsection (a), by inserting “, or other-  
 19                 wise,” after “entities”; and

20                 (2) in subsection (e)—

21                         (A) in paragraph (1), in the matter pre-  
 22                         ceding subparagraph (A), by inserting “(includ-  
 23                         ing the costs of equipment, salaries and bene-  
 24                         fits, and travel and training)” after “Program  
 25                         under this section”; and



1 (B) in paragraph (3), by striking “by 100”  
2 and inserting “by 100, or such number as de-  
3 termined necessary by the Secretary to carry  
4 out the Program under this section,”.

5 (d) ACCESS TO THE NATIONAL DIRECTORY OF NEW  
6 HIRES.—Section 453(j) of the Social Security Act (42  
7 U.S.C. 653(j)) is amended by adding at the end the fol-  
8 lowing new paragraph:

9 “(12) INFORMATION COMPARISONS AND DIS-  
10 CLOSURES TO ASSIST IN ADMINISTRATION OF THE  
11 MEDICARE PROGRAM AND STATE HEALTH SUBSIDY  
12 PROGRAMS.—

13 “(A) DISCLOSURE TO THE ADMINIS-  
14 TRATOR OF THE CENTERS FOR MEDICARE &  
15 MEDICAID SERVICES.—The Administrator of  
16 the Centers for Medicare & Medicaid shall have  
17 access to the information in the National Direc-  
18 tory of New Hires for purposes of determining  
19 the eligibility of an applicant for, or enrollee in,  
20 the Medicare program under title XVIII or an  
21 applicable State health subsidy program (as de-  
22 fined in section 1413(e) of the Patient Protec-  
23 tion and Affordable Care Act (42 U.S.C.  
24 18083(e)).

1           “(B) DISCLOSURE TO THE INSPECTOR  
2           GENERAL OF THE DEPARTMENT OF HEALTH  
3           AND HUMAN SERVICES.—

4           “(i) IN GENERAL.—If the Inspector  
5           General of the Department of Health and  
6           Human Services transmits to the Secretary  
7           the names and social security account  
8           numbers of individuals, the Secretary shall  
9           disclose to the Inspector General informa-  
10          tion on such individuals and their employ-  
11          ers maintained in the National Directory  
12          of New Hires.

13          “(ii) USE OF INFORMATION.—The In-  
14          specter General of the Department of  
15          Health and Human Services may use in-  
16          formation provided under clause (i) only  
17          for purposes of —

18                 “(I) enforcing mandatory and  
19                 permissive exclusions under title XI;  
20                 or

21                 “(II) evaluating the integrity of  
22                 the Medicare program or an applica-  
23                 ble State health subsidy program (as  
24                 defined in section 1413(e) of the Pa-

1                   tient Protection and Affordable Care  
2                   Act).

3                   The authority under this clause is in addi-  
4                   tion to any authority conferred under the  
5                   Inspector General Act of 1978 (5 U.S.C.  
6                   App).

7                   “(C) DISCLOSURE TO STATE AGENCIES.—

8                   “(i) IN GENERAL.—If, for purposes of  
9                   determining the eligibility of an applicant  
10                  for, or an enrollee in, an applicable State  
11                  health subsidy program (as defined in sec-  
12                  tion 1413(e) of the Patient Protection and  
13                  Affordable Care Act (42 U.S.C. 18083(e)),  
14                  a State agency responsible for admin-  
15                  istering such program transmits to the  
16                  Secretary the names, dates of birth, and  
17                  social security account numbers of individ-  
18                  uals, the Secretary shall disclose to such  
19                  State agency information on such individ-  
20                  uals and their employers maintained in the  
21                  National Directory of New Hires, subject  
22                  to this subparagraph.

23                  “(ii) CONDITION ON DISCLOSURE BY  
24                  THE SECRETARY.—The Secretary shall  
25                  make a disclosure under clause (i) only to

1 the extent that the Secretary determines  
2 that the disclosure would not interfere with  
3 the effective operation of the program  
4 under this part.

5 “(iii) USE AND DISCLOSURE OF IN-  
6 FORMATION BY STATE AGENCIES.—

7 “(I) IN GENERAL.—A State  
8 agency may not use or disclose infor-  
9 mation provided under clause (i) ex-  
10 cept for purposes of determining the  
11 eligibility of an applicant for, or an  
12 enrollee in, a program referred to in  
13 clause (i).

14 “(II) INFORMATION SECURITY.—  
15 The State agency shall have in effect  
16 data security and control policies that  
17 the Secretary finds adequate to ensure  
18 the security of information obtained  
19 under clause (i) and to ensure that  
20 access to such information is re-  
21 stricted to authorized persons for pur-  
22 poses of authorized uses and disclo-  
23 sures.

24 “(III) PENALTY FOR MISUSE OF  
25 INFORMATION.—An officer or em-

1            ployee of the State agency who fails to  
 2            comply with this clause shall be sub-  
 3            ject to the sanctions under subsection  
 4            (l)(2) to the same extent as if such of-  
 5            ficer or employee were an officer or  
 6            employee of the United States.

7            “(iv) PROCEDURAL REQUIREMENTS.—  
 8            State agencies requesting information  
 9            under clause (i) shall adhere to uniform  
 10           procedures established by the Secretary  
 11           governing information requests and data  
 12           matching under this paragraph.

13           “(v) REIMBURSEMENT OF COSTS.—  
 14           The State agency shall reimburse the Sec-  
 15           retary, in accordance with subsection  
 16           (k)(3), for the costs incurred by the Sec-  
 17           retary in furnishing the information re-  
 18           quested under this subparagraph.”.

19           (e) IMPROVING THE SHARING OF DATA BETWEEN  
 20           THE FEDERAL GOVERNMENT AND STATE MEDICAID PRO-  
 21           GRAMS.—

22           (1) IN GENERAL.—The Secretary of Health and  
 23           Human Services (in this subsection referred to as  
 24           the “Secretary”) shall establish a plan to encourage  
 25           and facilitate the participation of States in the Medi-

1 care-Medicaid Data Match Program (commonly re-  
 2 ferred to as the “Medi-Medi Program”) under sec-  
 3 tion 1893(g) of the Social Security Act (42 U.S.C.  
 4 1395ddd(g)).

5 (2) PROGRAM REVISIONS TO IMPROVE MEDI-  
 6 MEDI DATA MATCH PROGRAM PARTICIPATION BY  
 7 STATES.—Section 1893(g)(1)(A) of the Social Secu-  
 8 rity Act (42 U.S.C. 1395ddd(g)(1)(A)) is amend-  
 9 ed—

10 (A) in the matter preceding clause (i), by  
 11 inserting “or otherwise” after “eligible enti-  
 12 ties”;

13 (B) in clause (i)—

14 (i) by inserting “to review claims  
 15 data” after “algorithms”; and

16 (ii) by striking “service, time, or pa-  
 17 tient” and inserting “provider, service,  
 18 time, or patient”;

19 (C) in clause (ii)—

20 (i) by inserting “to investigate and re-  
 21 cover amounts with respect to suspect  
 22 claims” after “appropriate actions”; and

23 (ii) by striking “; and” and inserting  
 24 a semicolon;

1 (D) in clause (iii), by striking the period  
2 and inserting “; and”; and

3 (E) by adding at end the following new  
4 clause:

5 “(iv) furthering the Secretary’s de-  
6 sign, development, installation, or enhance-  
7 ment of an automated data system archi-  
8 tecture—

9 “(I) to collect, integrate, and as-  
10 sess data for purposes of program in-  
11 tegrity, program oversight, and ad-  
12 ministration, including the Medi-Medi  
13 Program; and

14 “(II) that improves the coordina-  
15 tion of requests for data from  
16 States.”.

17 (3) PROVIDING STATES WITH DATA ON IM-  
18 PROPER PAYMENTS MADE FOR ITEMS OR SERVICES  
19 PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

20 (A) IN GENERAL.—The Secretary shall de-  
21 velop and implement a plan that allows each  
22 State agency responsible for administering a  
23 State plan for medical assistance under title  
24 XIX of the Social Security Act access to rel-  
25 evant 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



1        what can be done to improve the likelihood patients  
2        receive the care they want and need.

3            (2) Research suggests that patients often do  
4        not receive the care they want. As a result, the end  
5        of life is associated with a substantial burden of suf-  
6        fering by the patient and negative health and finan-  
7        cial consequences that extend to family members and  
8        society.

9            (3) Patients face a complex and fragmented  
10       health care system that may decrease the likelihood  
11       that health care choices are known and carried out.  
12       The health care system should embed principles that  
13       take into account patient wishes.

14           (4) Decisions concerning health care, including  
15       end-of-life issues, affect an increasing number of  
16       Americans.

17           (5) Medical advances are prolonging life expect-  
18       ancy in the United States both in acute life-threat-  
19       ening situations and protracted battles with illness.  
20       These advances raise new challenges surrounding  
21       health care decision-making.

22           (6) The United States health care system  
23       should promote consideration of a person's pref-  
24       erence in health care decision-making and end-of-life  
25       choices.

1 (b) COMMISSION.—The Social Security Act is amend-  
2 ed by inserting after section 1150B (42 U.S.C. 1320b-  
3 24) the following new section:

4 **“SEC. 1150C. COMMISSION ON IMPROVING PATIENT DI-**  
5 **RECTED HEALTH CARE.**

6 “(a) PURPOSES.—The purposes of this section are  
7 to—

8 “(1) provide a forum for a nationwide public  
9 debate on improving patient self-determination in  
10 health care decision-making;

11 “(2) identify strategies that ensure every Amer-  
12 ican has the health care they want; and

13 “(3) provide recommendations to Congress that  
14 result from the debate.

15 “(b) ESTABLISHMENT.—The Secretary shall estab-  
16 lish an entity to be known as the Commission on Improv-  
17 ing Patient Directed Health Care (referred to in this sec-  
18 tion as the ‘Commission’).

19 “(c) MEMBERSHIP.—

20 “(1) NUMBER AND APPOINTMENT.—The Com-  
21 mission shall be composed of 15 members. One  
22 member shall be the Secretary. The Comptroller  
23 General of the United States shall appoint 14 mem-  
24 bers.

1           “(2) QUALIFICATIONS.—The membership of the  
2       Commission shall include—

3           “(A) health care consumers impacted by  
4       decision-making in advance of a health care cri-  
5       sis, such as individuals of advanced age, indi-  
6       viduals with chronic, terminal and mental ill-  
7       nesses, family care givers, and individuals with  
8       disabilities;

9           “(B) providers in settings where crucial  
10      health care decision-making occurs, such as  
11      those working in intensive care settings, emer-  
12      gency room departments, primary care settings,  
13      nursing homes, hospice, or palliative care set-  
14      tings;

15          “(C) payors ensuring patients get the level  
16      of care they want;

17          “(D) experts in advance care planning,  
18      hospice, palliative care, information technology,  
19      bioethics, aging policy, disability policy, pedi-  
20      atric ethics, cultural sensitivity, psychology, and  
21      health care financing;

22          “(E) individuals who represent culturally  
23      diverse perspectives on patient self-determina-  
24      tion and end-of-life issues; and

25          “(F) members of the faith community.

1       “(d) PERIOD OF APPOINTMENT.—Members of the  
 2 Commission shall be appointed for the life of the Commis-  
 3 sion. Any vacancies shall not affect the power and duties  
 4 of the Commission but shall be filled in the same manner  
 5 as the original appointment.

6       “(e) DESIGNATION OF THE CHAIRPERSON.—Not  
 7 later than 15 days after the date on which all members  
 8 of the Commission have been appointed, the Comptroller  
 9 General shall designate the chairperson of the Commis-  
 10 sion.

11       “(f) SUBCOMMITTEES.—The Commission may estab-  
 12 lish subcommittees if doing so increases the efficiency of  
 13 the Commission in completing tasks.

14       “(g) DUTIES.—

15               “(1) HEARINGS.—Not later than 90 days after  
 16 the date of designation of the chairperson under  
 17 subsection (e), the Commission shall hold no fewer  
 18 than 8 hearings to examine—

19                       “(A) the current state of health care deci-  
 20 sion-making and advance care planning laws in  
 21 the United States at the Federal level and  
 22 across the States, as well as options for improv-  
 23 ing advance care planning tools, especially with  
 24 regard to use, portability, and storage;

1           “(B) consumer-focused approaches that  
2           educate the American public about patient  
3           choices, care planning, and other end-of-life  
4           issues;

5           “(C) the use of comprehensive, patient-cen-  
6           tered care plans by providers, the impact care  
7           plans have on health care delivery and spend-  
8           ing, and methods to expand the use of high  
9           quality care planning tools in both public and  
10          private health care systems;

11          “(D) the role of electronic medical records  
12          and other technologies in improving patient-di-  
13          rected health care;

14          “(E) innovative tools for improving patient  
15          experience with advanced illness, such as pallia-  
16          tive care, hospice, and other models;

17          “(F) the role social determinants of health,  
18          such as socio-economic status, play in patient  
19          self-direction in health care;

20          “(G) the use of culturally-competent tools  
21          for health care decision-making;

22          “(H) strategies for educating providers  
23          and increasing provider engagement on care  
24          planning, palliative care, hospice care, and

1           other issues surrounding honoring patient  
2           choices;

3           “(I) the sociological and psychological fac-  
4           tors that influence health care decision-making  
5           and end-of-life choices; and

6           “(J) the role of spirituality and religion in  
7           patient self-determination in health care.

8           “(2) ADDITIONAL HEARINGS.—The Commission  
9           may hold additional hearings on subjects other than  
10          those listed in paragraph (1) so long as such hear-  
11          ings are determined necessary by the Commission in  
12          carrying out the purposes of this section. Such addi-  
13          tional hearings do not have to be completed within  
14          the time period specified but shall not delay the  
15          other activities of the Commission under this sec-  
16          tion.

17          “(3) NUMBER AND LOCATION OF HEARINGS  
18          AND ADDITIONAL HEARINGS.—The Commission shall  
19          hold no fewer than 8 hearings as indicated in para-  
20          graph (1) and in sufficient number in order to re-  
21          ceive information that reflects—

22                  “(A) the geographic differences throughout  
23                  the United States;

24                  “(B) diverse populations; and

1           “(C) a balance among urban and rural  
2           populations.

3           “(4) INTERACTIVE TECHNOLOGY.—The Com-  
4           mission may encourage public participation in hear-  
5           ings through interactive technology and other means  
6           as determined appropriate by the Commission.

7           “(5) REPORT TO THE AMERICAN PEOPLE ON  
8           PATIENT DIRECTED HEALTH CARE.—Not later than  
9           90 days after the hearings described in paragraphs  
10          (1) and (2) are completed, the Commission shall  
11          prepare and make available to health care consumers  
12          through the Internet and other appropriate public  
13          channels, a report to be entitled, ‘Report to the  
14          American People on Patient Directed Health Care’.  
15          Such a report shall be understandable to the general  
16          public and include—

17               “(A) a summary of—

18                   “(i) the hearings described in such  
19                   paragraphs;

20                   “(ii) how the current health care sys-  
21                   tem empowers and informs decision-mak-  
22                   ing in advance of a health care crisis;

23                   “(iii) factors that contribute to the  
24                   provision of health care that does not ad-  
25                   here to patient wishes;

1           “(iv) the impact of care that does not  
2 follow patient choices, particularly at the  
3 end-of-life, on patients, families, providers,  
4 spending, and the health care system;

5           “(v) the laws surrounding advance  
6 care planning and health care decision-  
7 making including issues of portability, use,  
8 and storage;

9           “(vi) consumer-focused approaches to  
10 education of the American public about pa-  
11 tient choices, care planning, and other end-  
12 of-life issues;

13           “(vii) the role of care plans in health  
14 care decision-making;

15           “(viii) the role of providers in ensur-  
16 ing patients receive the care they want;

17           “(ix) the role of electronic medical  
18 records and other technologies in improv-  
19 ing patient directed health care;

20           “(x) the impact of social determinants  
21 on patient self-direction in health care  
22 services;

23           “(xi) the use of culturally competent  
24 methods for health care decision-making;



1                   “(xii) the sociological and psycho-  
 2                   logical factors that influence patient self-  
 3                   determination; and

4                   “(xiii) the role of spirituality and reli-  
 5                   gion in health care decision-making and  
 6                   end-of-life care;

7                   “(B) best practices from communities, pro-  
 8                   viders, and payors that document patient wish-  
 9                   es and provide health care that adheres to those  
 10                  wishes; and

11                  “(C) information on educating providers  
 12                  about health care decision-making and end-of-  
 13                  life issues.

14                  “(6) INTERIM REQUIREMENTS.—Not later than  
 15                  180 days after the date of completion of the hear-  
 16                  ings, the Commission shall prepare and make avail-  
 17                  able to the public through the Internet and other ap-  
 18                  propriate public channels, an interim set of rec-  
 19                  ommendations on patient self-determination in  
 20                  health care and ways to improve and strengthen the  
 21                  health care system based on the information and  
 22                  preferences expressed at the community meetings.  
 23                  There shall be a 90-day public comment period on  
 24                  such recommendations.

1       “(h) RECOMMENDATIONS.—Not later than 120 days  
2 after the expiration of the public comment period de-  
3 scribed in subsection (g)(6), the Commission shall submit  
4 to Congress and the President a final set of recommenda-  
5 tions. The recommendations must be comprehensive and  
6 detailed. The recommendations must contain rec-  
7 ommendations or proposals for legislative or administra-  
8 tive action as the Commission deems appropriate, includ-  
9 ing proposed legislative language to carry out the rec-  
10 ommendations or proposals.

11       “(i) ADMINISTRATION.—

12               “(1) EXECUTIVE DIRECTOR.—There shall be an  
13 Executive Director of the Commission who shall be  
14 appointed by the chairperson of the Commission in  
15 consultation with the members of the Commission.

16               “(2) COMPENSATION.—While serving on the  
17 business of the Commission (including travel time),  
18 a member of the Commission shall be entitled to  
19 compensation at the per diem equivalent of the rate  
20 provided for level IV of the Executive Schedule  
21 under section 5315 of title 5, United States Code,  
22 and while so serving away from home and the mem-  
23 ber’s regular place of business, a member may be al-  
24 lowed travel expenses, as authorized by the chair-  
25 person of the Commission. For purposes of pay and

1 employment benefits, rights, and privileges, all per-  
2 sonnel of the Commission shall be treated as if they  
3 were employees of the Senate.

4 “(3) INFORMATION FROM FEDERAL AGEN-  
5 CIES.—The Commission may secure directly from  
6 any Federal department or agency such information  
7 as the Commission considers necessary to carry out  
8 this section. Upon request of the Commission the  
9 head of such department or agency shall furnish  
10 such information.

11 “(4) POSTAL SERVICES.—The Commission may  
12 use the United States mails in the same manner and  
13 under the same conditions as other departments and  
14 agencies of the Federal Government.

15 “(j) DETAIL.—Not more than 4 Federal Government  
16 employees employed by the Department of Labor, 4 Fed-  
17 eral Government employees employed by the Social Secu-  
18 rity Administration, and 8 Federal Government employees  
19 employed by the Department of Health and Human Serv-  
20 ices may be detailed to the Commission under this section  
21 without further reimbursement. Any detail of an employee  
22 shall be without interruption or loss of civil service status  
23 or privilege.

24 “(k) TEMPORARY AND INTERMITTENT SERVICES.—  
25 The chairperson of the Commission may procure tem-

1 porary and intermittent services under section 3109(b) of  
2 title 5, United States Code, at rates for individuals which  
3 do not exceed the daily equivalent of the annual rate of  
4 basic pay prescribed for level V of the Executive Schedule  
5 under section 5316 of such title.

6 “(l) ANNUAL REPORT.—Not later than 1 year after  
7 the date of enactment of this Act, and annually thereafter  
8 during the existence of the Commission, the Commission  
9 shall report to Congress and make public a detailed de-  
10 scription of the expenditures of the Commission used to  
11 carry out its duties under this section.

12 “(m) SUNSET OF COMMISSION.—The Commission  
13 shall terminate on the date that is 3 years after the date  
14 on which all the members of the Commission have been  
15 appointed under subsection (c)(1) and appropriations are  
16 first made available to carry out this section.

17 “(n) ADMINISTRATION REVIEW AND COMMENTS.—  
18 Not later than 45 days after receiving the final rec-  
19 ommendations of the Commission under subsection (h),  
20 the President shall submit a report to Congress which  
21 shall contain—

22 “(1) additional views and comments on such  
23 recommendations; and

1 “(2) recommendations for such legislation and  
 2 administrative action as the President considers ap-  
 3 propriate.

4 “(o) AUTHORIZATION OF APPROPRIATIONS.—

5 “(1) IN GENERAL.—There are authorized to be  
 6 appropriated to carry out this section, \$3,000,000  
 7 for each of fiscal years 2014 and 2015.

8 “(2) REPORT TO THE AMERICAN PEOPLE ON  
 9 PATIENT DIRECTED HEALTH CARE.—There are au-  
 10 thorized to be appropriated for the preparation and  
 11 dissemination of the Report to the American People  
 12 on Patient Directed Health Care described in sub-  
 13 section (g)(5), \$1,000,000 for the fiscal year in  
 14 which the report is required to be submitted.”.

15 **SEC. 402. EXPANSION OF THE DEFINITION OF INPATIENT**  
 16 **HOSPITAL SERVICES FOR CERTAIN CANCER**  
 17 **HOSPITALS.**

18 Section 1861(b) of the Social Security Act (42 U.S.C.  
 19 1395x(b)) is amended—

20 (1) in paragraph (3)—

21 (A) by inserting “(A)” after “(3)”;

22 (B) by adding “and” after the semicolon  
 23 at the end; and

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

1 “(B) subject to the third sentence of this  
 2 subsection, with respect to a hospital that—

3 “(i) is described in section  
 4 1886(d)(1)(B)(v); and

5 “(ii) as of the date of the enactment  
 6 of the Responsible Medicare SGR Repeal  
 7 and Beneficiary Access Improvement Act  
 8 of 2014, is located in the same building, or  
 9 on the same campus, as another hospital  
 10 (as described in sections 412.22(e) and  
 11 412.22(f) of title 42, Code of Federal Reg-  
 12 ulations, as in effect on such date of enact-  
 13 ment );

14 items and services described in paragraphs (1)  
 15 and (2) furnished on or after October 1, 2014,  
 16 by such hospital described in section  
 17 1886(d)(1)(B)(v) or by others under arrange-  
 18 ments with them made by the hospital;” and

19 (2) by adding at the end the following new  
 20 flush sentence:

21 “Paragraph (3)(B) shall only apply to payments with re-  
 22 spect to the total number of the hospital’s patient days  
 23 at any satellite of the hospital or such days at another  
 24 hospital providing services under arrangements to the hos-  
 25 pital, determined as of the date of the enactment of the

1 Responsible Medicare SGR Repeal and Beneficiary Access  
2 Improvement Act of 2014.”.

3 **SEC. 403. QUALITY MEASURES FOR CERTAIN POST-ACUTE**  
4 **CARE PROVIDERS RELATING TO NOTICE AND**  
5 **TRANSFER OF PATIENT HEALTH INFORMA-**  
6 **TION AND PATIENT CARE PREFERENCES.**

7 (a) DEVELOPMENT.—The Secretary of Health and  
8 Human Services (in this section referred to as the “Sec-  
9 retary”) shall provide for the development of one or more  
10 quality measures under title XVIII of the Social Security  
11 Act (42 U.S.C. 1395 et seq.) to accurately communicate  
12 the existence and provide for the transfer of patient health  
13 information and patient care preferences when an indi-  
14 vidual transitions from a hospital to return home or move  
15 to other post-acute care settings.

16 (b) USE OF MEASURE DEVELOPERS.—The Secretary  
17 shall arrange for the development of such measures by ap-  
18 propriate measure developers.

19 (c) ENDORSEMENT.—The Secretary shall arrange for  
20 such developed measures to be submitted for endorsement  
21 to a consensus-based entity as described in section  
22 1890(a) of the Social Security Act (42 U.S.C.  
23 1395aaa(a)).

24 (d) USE OF MEASURES.—The Secretary shall,  
25 through notice and comment rulemaking, use such meas-

ures 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 Sec-  
retary 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



1 title 42, Code of Federal Regulation, as finalized in  
2 the final rule published by the Centers for Medicare  
3 & Medicaid Services in the Federal Register on Au-  
4 gust 19, 2013 (78 Federal Register 50496) entitled  
5 “Medicare Program; Hospital Inpatient Prospective  
6 Payment Systems for Acute Care Hospitals and the  
7 Long-Term Care Hospital Prospective Payment Sys-  
8 tem and Fiscal Year 2014 Rates; Quality Reporting  
9 Requirements for Specific Providers; Hospital Con-  
10 ditions of Participation; Payment Policies Related to  
11 Patient Status”.

12 (b) INTERESTED STAKEHOLDERS.—In subsection  
13 (a), the term “interested stakeholders” means the fol-  
14 lowing:

15 (1) Hospitals.

16 (2) Physicians

17 (3) Medicare administrative contractors under  
18 section 1874A of the Social Security Act (42 U.S.C.  
19 1395kk–1).

20 (4) Recovery audit contractors under section  
21 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

22 (5) Other parties determined appropriate by the  
23 Secretary.

1 **SEC. 405. TRANSPARENCY OF REASONS FOR EXCLUDING**  
 2 **ADDITIONAL PROCEDURES FROM THE MEDI-**  
 3 **CARE AMBULATORY SURGICAL CENTER (ASC)**  
 4 **APPROVED LIST.**

5 Section 1833(i)(1) of the Social Security Act (42  
 6 U.S.C. 1395l(i)(1)) is amended by adding at the end the  
 7 following: “In updating such lists for application in years  
 8 beginning after December 31, 2014, for each procedure  
 9 that was not proposed but was requested to be included  
 10 on such lists during the public comment where the Sec-  
 11 retary does not finalize (in the final rule updating such  
 12 lists) to so include, the Secretary shall describe in such  
 13 final rule the specific safety criteria for not including such  
 14 requested procedure on such lists.”.

15 **SEC. 406. SUPERVISION IN CRITICAL ACCESS HOSPITALS.**

16 (a) GENERAL SUPERVISION IN CRITICAL ACCESS  
 17 HOSPITALS.—Section 1834(g) of the Social Security Act  
 18 (42 U.S.C. 1395m(g)) is amended by adding at the end  
 19 the following new paragraph:

20 “(6) SUPERVISION.—In the case of services fur-  
 21 nished on or after the date of the enactment of this  
 22 paragraph, the minimum level of supervision with re-  
 23 spect to outpatient therapeutic critical access hos-  
 24 pital services shall be general supervision (as defined  
 25 by the Secretary).”.

1 (b) SUPERVISION OF CARDIAC AND PULMONARY RE-  
 2 HABILITATION PROGRAMS IN CRITICAL ACCESS HOS-  
 3 PITALS.—Section 1861(eee)(2)(B) of the Social Security  
 4 Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting  
 5 “, or in the case of a critical access hospital, a physician,  
 6 or (beginning on the date of enactment of Responsible  
 7 Medicare SGR Repeal and Beneficiary Access Improve-  
 8 ment Act of 2014) a nurse practitioner, clinical nurse spe-  
 9 cialist, or physician assistant (as such terms are defined  
 10 in subsection (aa)(5)),” after “a physician”.

11 **SEC. 407. REQUIRING STATE LICENSURE OF BIDDING ENTI-**  
 12 **TIES UNDER THE COMPETITIVE ACQUISITION**  
 13 **PROGRAM FOR CERTAIN DURABLE MEDICAL**  
 14 **EQUIPMENT, PROSTHETICS, ORTHOTICS, AND**  
 15 **SUPPLIES (DMEPOS).**

16 Section 1847(a)(1) of the Social Security Act (42  
 17 U.S.C. 1395w–3(a)(1)) is amended by adding at the end  
 18 the following new subparagraph:

19 “(G) REQUIRING STATE LICENSURE OF  
 20 BIDDING ENTITIES.—With respect to rounds of  
 21 competitions beginning on or after the date of  
 22 enactment of this subparagraph, the Secretary  
 23 may only accept a bid from an entity for an  
 24 area if the entity meets applicable State licen-

1           sure requirements for such area for all items in  
2           such bid for a product category.”.

3 **SEC. 408. RECOGNITION OF ATTENDING PHYSICIAN ASSIST-**  
4 **ANTS AS ATTENDING PHYSICIANS TO SERVE**  
5 **HOSPICE PATIENTS.**

6           (a) RECOGNITION OF ATTENDING PHYSICIAN AS-  
7 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOS-  
8 PICE PATIENTS.—

9           (1) IN GENERAL.—Section 1861(dd)(3)(B) of  
10 the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))  
11 is amended—

12                   (A) by striking “or nurse” and inserting “,  
13 the nurse”; and

14                   (B) by inserting “, or the physician assist-  
15 ant (as defined in such subsection)” after “sub-  
16 section (aa)(5))”.

17           (2) CLARIFICATION OF HOSPICE ROLE OF PHY-  
18 SICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of  
19 the Social Security Act (42 U.S.C.  
20 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a  
21 physician assistant” after “a nurse practitioner”.

22           (b) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to items and services furnished on  
24 or after October 1, 2015.

1 **SEC. 409. REMOTE PATIENT MONITORING PILOT**  
2 **PROJECTS.**

3 (a) PILOT PROJECTS.—

4 (1) IN GENERAL.—Not later than 9 months  
5 after the date of the enactment of this Act, the Sec-  
6 retary shall conduct pilot projects under title XVIII  
7 of the Social Security Act for the purpose of pro-  
8 viding incentives to home health agencies to furnish  
9 remote patient monitoring services that reduce ex-  
10 penditures under such title.

11 (2) SITE REQUIREMENTS.—

12 (A) URBAN AND RURAL.—The Secretary  
13 shall conduct the pilot projects under this sec-  
14 tion in both urban and rural areas.

15 (B) SITE IN A SMALL STATE.—The Sec-  
16 retary shall conduct at least 1 of the pilot  
17 projects in a State with a population of less  
18 than 1,000,000.

19 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE  
20 OF PROJECTS.—

21 (1) IN GENERAL.—The Secretary shall specify  
22 the criteria for identifying those Medicare bene-  
23 ficiaries who shall be considered within the scope of  
24 the pilot projects under this section for purposes of  
25 the application of subsection (c) and for the assess-

1       ment of the effectiveness of the home health agency  
2       in achieving the objectives of this section.

3           (2) CRITERIA.—The criteria specified under  
4       paragraph (1)—

5           (A) shall include conditions and clinical  
6       circumstances, including congestive heart fail-  
7       ure, diabetes, and chronic pulmonary obstruc-  
8       tive disease, and other conditions determined  
9       appropriate by the Secretary; and

10          (B) may provide for the inclusion in the  
11       projects of Medicare beneficiaries who begin re-  
12       ceiving home health services under title XVIII  
13       of the Social Security Act after the date of the  
14       implementation of the projects.

15       (c) INCENTIVES.—

16           (1) PERFORMANCE TARGETS.—The Secretary  
17       shall establish for each home health agency partici-  
18       pating in a pilot project under this section a per-  
19       formance target using one of the following meth-  
20       odologies, as determined appropriate by the Sec-  
21       retary:

22           (A) ADJUSTED HISTORICAL PERFORMANCE  
23       TARGET.—The Secretary shall establish for the  
24       agency—

1 (i) a base expenditure amount equal  
2 to the average total payments made under  
3 parts A, B, and D of title XVIII of the So-  
4 cial Security Act for Medicare beneficiaries  
5 determined to be within the scope of the  
6 pilot project in a base period determined  
7 by the Secretary; and

8 (ii) an annual per capita expenditure  
9 target for such beneficiaries, reflecting the  
10 base expenditure amount adjusted for risk,  
11 changes in costs, and growth rates.

12 (B) COMPARATIVE PERFORMANCE TAR-  
13 GET.—The Secretary shall establish for the  
14 agency a comparative performance target equal  
15 to the average total payments made under such  
16 parts A, B, and D during the pilot project for  
17 comparable individuals in the same geographic  
18 area that are not determined to be within the  
19 scope of the pilot project.

20 (2) PAYMENT.—Subject to paragraph (3), the  
21 Secretary shall pay to each home health agency par-  
22 ticipating in a pilot project a payment for each year  
23 under the pilot project equal to a 75 percent share  
24 of the total Medicare cost savings realized for such

1 year relative to the performance target under para-  
2 graph (1).

3 (3) LIMITATION ON EXPENDITURES.—The Sec-  
4 retary shall limit payments under this section in  
5 order to ensure that the aggregate expenditures  
6 under title XVIII of the Social Security Act (includ-  
7 ing payments under this subsection) do not exceed  
8 the amount that the Secretary estimates would have  
9 been expended if the pilot projects under this section  
10 had not been implemented, including any reasonable  
11 costs incurred by the Secretary in the administration  
12 of the pilot projects.

13 (4) NO DUPLICATION IN PARTICIPATION IN  
14 SHARED SAVINGS PROGRAMS.—A home health agen-  
15 cy that participates in any of the following shall not  
16 be eligible to participate in the pilot projects under  
17 this section:

18 (A) A model tested or expanded under sec-  
19 tion 1115A of the Social Security Act (42  
20 U.S.C. 1315a) that involves shared savings  
21 under title XVIII of such Act or any other pro-  
22 gram or demonstration project that involves  
23 such shared savings.



1 (B) The independence at home medical  
2 practice demonstration program under section  
3 1866E of such Act (42 U.S.C. 1395cc–5).

4 (d) WAIVER AUTHORITY.—The Secretary may waive  
5 such provisions of titles XI and XVIII of the Social Secu-  
6 rity Act as the Secretary determines to be appropriate for  
7 the conduct of the pilot projects under this section.

8 (e) REPORT TO CONGRESS.—Not later than 3 years  
9 after the date that the first pilot project under this section  
10 is implemented, the Secretary shall submit to Congress a  
11 report on the projects. Such report shall contain—

12 (1) a detailed description of the projects, in-  
13 cluding any changes in clinical outcomes for Medi-  
14 care beneficiaries under the projects, Medicare bene-  
15 ficiary satisfaction under the projects, utilization of  
16 items and services under parts A, B, and D of title  
17 XVIII of the Social Security Act by Medicare bene-  
18 ficiaries under the projects, and Medicare per-bene-  
19 ficiary and Medicare aggregate spending under the  
20 projects;

21 (2) a detailed description of issues related to  
22 the expansion of the projects under subsection (f);

23 (3) recommendations for such legislation and  
24 administrative actions as the Secretary considers ap-  
25 propriate; and

1           (4) other items considered appropriate by the  
2       Secretary.

3       (f) EXPANSION.—If the Secretary determines that  
4 any of the pilot projects under this section enhance health  
5 outcomes for Medicare beneficiaries and reduce expendi-  
6 tures under title XVIII of the Social Security Act, the Sec-  
7 retary shall initiate comparable projects in additional  
8 areas.

9       (g) PAYMENTS HAVE NO EFFECT ON OTHER MEDI-  
10 CARE PAYMENTS TO HOME HEALTH AGENCIES.—A pay-  
11 ment under this section shall have no effect on the amount  
12 of payments that a home health agency would otherwise  
13 receive under title XVIII of the Social Security Act for  
14 the provision of home health services.

15       (h) STUDY AND REPORT ON THE APPROPRIATE  
16 VALUATION FOR REMOTE PATIENT MONITORING SERV-  
17 ICES UNDER THE MEDICARE PHYSICIAN FEE SCHED-  
18 ULE.—

19           (1) STUDY.—The Secretary shall conduct a  
20 study on the appropriate valuation for remote pa-  
21 tient monitoring services under the Medicare physi-  
22 cian fee schedule under section 1848 of the Social  
23 Security Act (42 U.S.C. 1395w–4) in order to accu-  
24 rately reflect the resources involved in furnishing  
25 such services.

1           (2) REPORT.—Not later than 6 months after  
2           the date of the enactment of this Act, the Secretary  
3           shall submit to Congress a report on the study con-  
4           ducted under paragraph (1), together with such rec-  
5           ommendations as the Secretary determines appro-  
6           priate.

7           (i) DEFINITIONS.—In this section:

8           (1) HOME HEALTH AGENCY.—The term “home  
9           health agency” has the meaning given that term in  
10          section 1861(o) of the Social Security Act (42  
11          U.S.C. 1395x(o)).

12          (2) REMOTE PATIENT MONITORING SERV-  
13          ICES.—

14                (A) IN GENERAL.—The term “remote pa-  
15                tient monitoring services” means services fur-  
16                nished in the home using remote patient moni-  
17                toring technology which—

18                   (i) shall include patient monitoring or  
19                   patient assessment; and

20                   (ii) may include in-home technology-  
21                   based professional consultations, patient  
22                   training services, clinical observation,  
23                   treatment, and any additional services that  
24                   utilize technologies specified by the Sec-  
25                   retary.

1 (B) LIMITATION.—The term “remote pa-  
2 tient monitoring services” shall not include a  
3 telecommunication that consists solely of a tele-  
4 phone audio conversation, facsimile, or elec-  
5 tronic text mail between a health care profes-  
6 sional and a patient.

7 (3) REMOTE PATIENT MONITORING TECH-  
8 NOLOGY.—The term “remote patient monitoring  
9 technology” means a coordinated system that uses  
10 one or more home-based or mobile monitoring de-  
11 vices that automatically transmit vital sign data or  
12 information on activities of daily living and may in-  
13 clude responses to assessment questions collected on  
14 the devices wirelessly or through a telecommuni-  
15 cations connection to a server that complies with the  
16 Federal regulations (concerning the privacy of indi-  
17 vidually identifiable health information) promulgated  
18 under section 264(c) of the Health Insurance Port-  
19 ability and Accountability Act of 1996, as part of an  
20 established plan of care for that patient that in-  
21 cludes the review and interpretation of that data by  
22 a health care professional.

23 (4) SECRETARY.—The term “Secretary” means  
24 the Secretary of Health and Human Services.

1 **SEC. 410. COMMUNITY-BASED INSTITUTIONAL SPECIAL**  
2 **NEEDS PLAN DEMONSTRATION PROGRAM.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services (referred to in this section as the “Sec-  
5 retary”) shall establish a Community-Based Institutional  
6 Special Needs Plan (CBI-SNP) demonstration program to  
7 prevent and delay institutionalization under Medicaid  
8 among targeted low-income Medicare beneficiaries.

9 (b) ESTABLISHMENT.—The Secretary shall enter into  
10 agreements with not more than 5 specialized MA plans  
11 for special needs individuals, as defined in section  
12 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C.  
13 1395w–28(b)(6)(B)(i)), to conduct the CBI-SNP dem-  
14 onstration program. Under the CBI-SNP demonstration  
15 program, a targeted low-income Medicare beneficiary shall  
16 receive, as supplemental benefits under section 1852(a)(3)  
17 of such Act (42 U.S.C. 1395w–22(a)(3)), long-term care  
18 services or supports that—

19 (1) the Secretary determines appropriate for  
20 the purposes of the CBI-SNP demonstration pro-  
21 gram; and

22 (2) for which payment may be made under the  
23 State plan under title XIX of such Act (42 U.S.C.  
24 1396 et seq.) of the State in which the targeted low-  
25 income Medicare beneficiary is located.

1 (c) ELIGIBLE PLANS.—To be eligible to participate  
2 in the CBI-SNP demonstration program, a specialized MA  
3 plan for special needs individuals must—

4 (1) serve special needs individuals (as defined  
5 in section 1859(b)(6)(B)(i) of the Social Security  
6 Act (42 U.S.C. 1395w–28(b)(6)(B)(i));

7 (2) have experience in offering special needs  
8 plans for nursing home-eligible, non-institutionalized  
9 Medicare beneficiaries who live in the community;

10 (3) be located in a State that the Secretary has  
11 determined will participate in the CBI-SNP dem-  
12 onstration program by agreeing to make available  
13 data necessary for purposes of conducting the inde-  
14 pendent evaluation required under subsection (f);  
15 and

16 (4) meet such other criteria as the Secretary  
17 may require.

18 (d) TARGETED LOW-INCOME MEDICARE BENE-  
19 FICIARY DEFINED.—In this section, the term “targeted  
20 low-income Medicare beneficiary” means a Medicare bene-  
21 ficiary who—

22 (1) is enrolled in a specialized MA plan for spe-  
23 cial needs individuals that has been selected to par-  
24 ticipate in the CBI-SNP demonstration program;

1           (2) is a subsidy eligible individual (as defined in  
2           section 1860D–14(a)(3)(A) of the Social Security  
3           Act (42 U.S.C. 1395w-114(a)(3)(A)); and

4           (3) is unable to perform 2 or more activities of  
5           daily living (as defined in section 7702B(c)(2)(B) of  
6           the Internal Revenue Code of 1986).

7           (e) IMPLEMENTATION DEADLINE; DURATION.—The  
8           CBI-SNP demonstration program shall be implemented  
9           not later than January 1, 2016, and shall be conducted  
10          for a period of 3 years.

11          (f) INDEPENDENT EVALUATION AND REPORTS.—

12               (1) INDEPENDENT EVALUATION.—Not later  
13               than 2 years after the completion of the CBI-SNP  
14               demonstration program, the Secretary shall provide  
15               for the evaluation of the CBI-SNP demonstration  
16               program by an independent third party. The evalua-  
17               tion shall determine whether the CBI-SNP dem-  
18               onstration program has improved patient care and  
19               quality of life for the targeted low-income Medicare  
20               beneficiaries participating in the CBI-SNP dem-  
21               onstration program. Specifically, the evaluation shall  
22               determine if the CBI-SNP demonstration program  
23               has—

24                       (A) reduced hospitalizations or re-hos-  
25                       pitalizations;

1 (B) reduced Medicaid nursing home facility  
2 stays; and

3 (C) reduced spenddown of income and as-  
4 sets for purposes of becoming eligible for Med-  
5 icaid.

6 (2) REPORTS.—Not later than 3 years after the  
7 completion of the CBI-SNP demonstration program,  
8 the Secretary shall submit to Congress a report con-  
9 taining the results of the evaluation conducted under  
10 paragraph (1), together with such recommendations  
11 for legislative or administrative action as the Sec-  
12 retary determines appropriate.

13 (g) FUNDING.—

14 (1) FUNDING FOR IMPLEMENTATION.—For  
15 purposes of carrying out the demonstration program  
16 under this section (other than the evaluation and re-  
17 port under subsection (f)), the Secretary shall pro-  
18 vide for the transfer from the Federal Hospital In-  
19 surance Trust Fund under section 1817 of the So-  
20 cial Security Act (42 U.S.C. 1395i) and the Federal  
21 Supplementary Medical Insurance Trust Fund under  
22 section 1841 of such Act (42 U.S.C. 1395t), in such  
23 proportion as the Secretary determines appropriate,  
24 of \$3,000,000 to the Centers for Medicare & Med-  
25 icaid Services Program Management Account.



1           (2) FUNDING FOR EVALUATION AND REPORT.—

2           For purposes of carrying out the evaluation and re-  
3           port under subsection (f), the Secretary shall provide  
4           for the transfer from the Federal Hospital Insurance  
5           Trust Fund under such section 1817 and the Fed-  
6           eral Supplementary Medical Insurance Trust Fund  
7           under such section 1841, in such proportion as the  
8           Secretary determines appropriate, of \$500,000.

9           (3) AVAILABILITY.—Amounts transferred under  
10          paragraph (1) or (2) shall remain available until ex-  
11          pended.

12          (h) BUDGET NEUTRALITY.—In conducting the CBI-  
13          SNP demonstration program, the Secretary shall ensure  
14          that the aggregate payments made by the Secretary do  
15          not exceed the amount which the Secretary estimates  
16          would have been expended under titles XVIII and XIX  
17          of the Social Security Act (42 U.S.C. 1395 et seq., 1396  
18          et seq.) if the CBI-SNP demonstration program had not  
19          been implemented.

20          (i) PAPERWORK REDUCTION ACT.—Chapter 35 of  
21          title 44, United States Code, shall not apply to the testing  
22          and evaluation of the CBI-SNP demonstration program  
23          under this section.

1 **SEC. 411. APPLYING CMMI WAIVER AUTHORITY TO PACE IN**  
 2 **ORDER TO FOSTER INNOVATIONS.**

3 (a) CMMI WAIVER AUTHORITY.—Subsection (d)(1)  
 4 of section 1115A of the Social Security Act (42 U.S.C.  
 5 1315a) is amended—

6 (1) by inserting “(other than subsections  
 7 (b)(1)(A) and (c)(5) of section 1894)” after  
 8 “XVIII”; and

9 (2) by striking “and 1903(m)(2)(A)(iii)” and  
 10 inserting “1903(m)(2)(A)(iii), and 1934 (other than  
 11 subsections (b)(1)(A) and (c)(5) of such section)”.

12 (b) SENSE OF THE SENATE.—It is the sense of the  
 13 Senate that the Secretary of Health and Human Services  
 14 should use the waiver authority provided under the  
 15 amendments made by this section to provide, in a budget  
 16 neutral manner, programs of all-inclusive care for the el-  
 17 derly (PACE programs) with increased operational flexi-  
 18 bility to support the ability of such programs to improve  
 19 and innovate and to reduce technical and administrative  
 20 barriers that have hindered enrollment in such programs.

21 **SEC. 412. IMPROVE AND MODERNIZE MEDICAID DATA SYS-**  
 22 **TEMS AND REPORTING.**

23 (a) IN GENERAL.—The Secretary of Health and  
 24 Human Services shall implement a strategic plan to in-  
 25 crease the usefulness of data about State Medicaid pro-  
 26 grams reported by States to the Centers for Medicare &

1 Medicaid Services. The strategic plan shall address  
2 redundancies and gaps in Medicaid data systems and re-  
3 porting through improvements to, and modernization of,  
4 computer and data systems. Areas for improvement under  
5 the plan shall include (but not be limited to) the following:

6           (1) The reporting of encounter data by man-  
7           aged care plans.

8           (2) The timeliness and quality of reported data,  
9           including enrollment data.

10          (3) The consistency of data reported from mul-  
11          tiple sources.

12          (4) Information about State program policies.

13          (b) IMPLEMENTATION STATUS REPORT.—Not later  
14 than 1 year after the date of enactment of this Act, the  
15 Secretary of Health and Human Services shall submit a  
16 report to Congress on the status of the implementation  
17 of the strategic plan required under subsection (a).

18          (c) AUTHORIZATION OF APPROPRIATIONS.—There is  
19 authorized to be appropriated to the Secretary of Health  
20 and Human Services for the period of fiscal years 2015  
21 through 2019, such sums as may be necessary to carry  
22 out this section.

1 **SEC. 413. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS**  
 2 **TRUSTS.**

3 (a) IN GENERAL.—Section 1917(d)(4)(A) of the So-  
 4 cial Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended  
 5 by inserting “the individual,” after “for the benefit of such  
 6 individual by”.

7 (b) EFFECTIVE DATE.—The amendment made by  
 8 subsection (a) shall apply to trusts established on or after  
 9 the date of the enactment of this Act.

10 **SEC. 414. HELPING ENSURE LIFE- AND LIMB-SAVING AC-**  
 11 **CESS TO PODIATRIC PHYSICIANS.**

12 (a) INCLUDING PODIATRISTS AS PHYSICIANS UNDER  
 13 THE MEDICAID PROGRAM.—

14 (1) IN GENERAL.—Section 1905(a)(5)(A) of the  
 15 Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is  
 16 amended by striking “section 1861(r)(1)” and in-  
 17 serting “paragraphs (1) and (3) of section 1861(r)”.

18 (2) EFFECTIVE DATE.—

19 (A) IN GENERAL.—Except as provided in  
 20 subparagraph (B), the amendment made by  
 21 paragraph (1) shall apply to services furnished  
 22 on or after the date of enactment of this Act.

23 (B) EXTENSION OF EFFECTIVE DATE FOR  
 24 STATE LAW AMENDMENT.—In the case of a  
 25 State plan under title XIX of the Social Secu-  
 26 rity Act (42 U.S.C. 1396 et seq.) which the

1 Secretary of Health and Human Services deter-  
 2 mines requires State legislation in order for the  
 3 plan to meet the additional requirement im-  
 4 posed by the amendment made by paragraph  
 5 (1), the State plan shall not be regarded as fail-  
 6 ing to comply with the requirements of such  
 7 title solely on the basis of its failure to meet  
 8 these additional requirements before the first  
 9 day of the first calendar quarter beginning after  
 10 the close of the first regular session of the  
 11 State legislature that begins after the date of  
 12 enactment of this Act. For purposes of the pre-  
 13 vious sentence, in the case of a State that has  
 14 a 2-year legislative session, each year of the ses-  
 15 sion is considered to be a separate regular ses-  
 16 sion of the State legislature.

17 (b) MODIFICATIONS TO REQUIREMENTS FOR DIA-  
 18 BETIC SHOES TO BE INCLUDED UNDER MEDICAL AND  
 19 OTHER HEALTH SERVICES UNDER MEDICARE.—

20 (1) IN GENERAL.—Section 1861(s)(12) of the  
 21 Social Security Act (42 U.S.C. 1395x(s)(12)) is  
 22 amended to read as follows:

23 “(12) subject to section 4072(e) of the Omni-  
 24 bus Budget Reconciliation Act of 1987, extra-depth  
 25 shoes with inserts or custom molded shoes (in this

1 paragraph referred to as ‘therapeutic shoes’) with  
2 inserts for an individual with diabetes, if—

3 “(A) the physician who is managing the in-  
4 dividual’s diabetic condition—

5 “(i) documents that the individual has  
6 diabetes;

7 “(ii) certifies that the individual is  
8 under a comprehensive plan of care related  
9 to the individual’s diabetic condition; and

10 “(iii) documents agreement with the  
11 prescribing podiatrist or other qualified  
12 physician (as established by the Secretary)  
13 that it is medically necessary for the indi-  
14 vidual to have such extra-depth shoes with  
15 inserts or custom molded shoes with in-  
16 serts;

17 “(B) the therapeutic shoes are prescribed  
18 by a podiatrist or other qualified physician (as  
19 established by the Secretary) who—

20 “(i) examines the individual and de-  
21 termines the medical necessity for the indi-  
22 vidual to receive the therapeutic shoes; and

23 “(ii) communicates in writing the  
24 medical necessity to the physician de-  
25 scribed in subparagraph (A) for the indi-

vidual 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 com-

1 community behavioral health clinic for purposes of par-  
2 ticipating in a demonstration program conducted  
3 under subsection (d).

4 (2) REQUIREMENTS.—The criteria published  
5 under this subsection shall include criteria with re-  
6 spect to the following:

7 (A) STAFFING.—Staffing requirements, in-  
8 cluding criteria that staff have diverse discipli-  
9 nary backgrounds, have necessary State-re-  
10 quired license and accreditation, and are cul-  
11 turally and linguistically trained to serve the  
12 needs of the clinic’s patient population.

13 (B) AVAILABILITY AND ACCESSIBILITY OF  
14 SERVICES.—Availability and accessibility of  
15 services, including crisis management services  
16 that are available and accessible 24 hours a  
17 day, the use of a sliding scale for payment, and  
18 no rejection for services or limiting of services  
19 on the basis of a patient’s ability to pay or a  
20 place of residence.

21 (C) CARE COORDINATION.—Care coordina-  
22 tion, including requirements to coordinate care  
23 across settings and providers to ensure seamless  
24 transitions for patients across the full spectrum  
25 of health services including acute, chronic, and



1 behavioral health needs. Care coordination re-  
2 quirements shall include partnerships or formal  
3 contracts with the following:

4 (i) Federally-qualified health centers  
5 (and as applicable, rural health clinics) to  
6 provide Federally-qualified health center  
7 services (and as applicable, rural health  
8 clinic services) to the extent such services  
9 are not provided directly through the cer-  
10 tified community behavioral health clinic.

11 (ii) Inpatient psychiatric facilities and  
12 substance use detoxification, post-detoxi-  
13 fication step-down services, and residential  
14 programs.

15 (iii) Other community or regional  
16 services, supports, and providers, including  
17 schools, child welfare agencies, juvenile and  
18 criminal justice agencies and facilities, In-  
19 dian Health Service youth regional treat-  
20 ment centers, State licensed and nationally  
21 accredited child placing agencies for thera-  
22 peutic foster care service, and other social  
23 and human services.

24 (iv) Department of Veterans Affairs  
25 medical centers, independent outpatient

1 clinics, drop-in centers, and other facilities  
2 of the Department as defined in section  
3 1801 of title 38, United States Code.

4 (v) Inpatient acute care hospitals and  
5 hospital outpatient clinics.

6 (D) SCOPE OF SERVICES.—Provision (in a  
7 manner reflecting person-centered care) of the  
8 following services which, if not available directly  
9 through the certified community behavioral  
10 health clinic, are provided or referred through  
11 formal relationships with other providers:

12 (i) Crisis mental health services, in-  
13 cluding 24-hour mobile crisis teams, emer-  
14 gency crisis intervention services, and cri-  
15 sis stabilization.

16 (ii) Screening, assessment, and diag-  
17 nosis, including risk assessment.

18 (iii) Patient-centered treatment plan-  
19 ning or similar processes, including risk as-  
20 sessment and crisis planning.

21 (iv) Outpatient mental health and  
22 substance use services.

23 (v) Outpatient clinic primary care  
24 screening and monitoring of key health in-  
25 dicators and health risk.

1 (vi) Targeted case management.

2 (vii) Psychiatric rehabilitation serv-  
3 ices.

4 (viii) Peer support and counselor serv-  
5 ices and family supports.

6 (ix) Intensive, community-based men-  
7 tal health care for members of the armed  
8 forces and veterans, particularly those  
9 members and veterans located in rural  
10 areas, provided the care is consistent with  
11 minimum clinical mental health guidelines  
12 promulgated by the Veterans Health Ad-  
13 ministration including clinical guidelines  
14 contained in the Uniform Mental Health  
15 Services Handbook of such Administration.

16 (E) QUALITY AND OTHER REPORTING.—  
17 Reporting of encounter data, clinical outcomes  
18 data, quality data, and such other data as the  
19 Secretary requires.

20 (F) ORGANIZATIONAL AUTHORITY.—Cri-  
21 teria that a clinic be a non-profit or part of a  
22 local government behavioral health authority or  
23 operated under the authority of the Indian  
24 Health Service, an Indian tribe or tribal organi-  
25 zation pursuant to a contract, grant, coopera-

1           tive agreement, or compact with the Indian  
2           Health Service pursuant to the Indian Self-De-  
3           termination Act (25 U.S.C. 450 et seq.), or an  
4           urban Indian organization pursuant to a grant  
5           or contract with the Indian Health Service  
6           under title V of the Indian Health Care Im-  
7           provement Act (25 U.S.C. 1601 et seq.).

8           (b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE  
9           PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-  
10          TION PROGRAMS.—

11           (1) IN GENERAL.—Not later than September 1,  
12          2015, the Secretary, through the Administrator of  
13          the Centers for Medicare & Medicaid Services, shall  
14          issue guidance for the establishment of a prospective  
15          payment system that shall only apply to medical as-  
16          sistance for mental health services furnished by a  
17          certified community behavioral health clinic partici-  
18          pating in a demonstration program under subsection  
19          (d).

20           (2) REQUIREMENTS.—The guidance issued by  
21          the Secretary under paragraph (1) shall provide  
22          that—

23                   (A) no payment shall be made for inpatient  
24                   care, residential treatment, room and board ex-

1           penses, or any other non-ambulatory services,  
2           as determined by the Secretary; and

3           (B) no payment shall be made to satellite  
4           facilities of certified community behavioral  
5           health clinics if such facilities are established  
6           after the date of enactment of this Act.

7       (c) PLANNING GRANTS.—

8           (1) IN GENERAL.—Not later than January 1,  
9           2016, the Secretary shall award planning grants to  
10          States for the purpose of developing proposals to  
11          participate in time-limited demonstration programs  
12          described in subsection (d).

13          (2) USE OF FUNDS.—A State awarded a plan-  
14          ning grant under this subsection shall—

15               (A) solicit input with respect to the devel-  
16               opment of such a demonstration program from  
17               patients, providers, and other stakeholders;

18               (B) certify clinics as certified community  
19               behavioral health clinics for purposes of partici-  
20               pating in a demonstration program conducted  
21               under subsection (d); and

22               (C) establish a prospective payment system  
23               for mental health services furnished by a cer-  
24               tified community behavioral health clinic par-  
25               ticipating in a demonstration program under

1 subsection (d) in accordance with the guidance  
2 issued under subsection (b).

3 (d) DEMONSTRATION PROGRAMS.—

4 (1) IN GENERAL.—Not later than September 1,  
5 2017, the Secretary shall select States to participate  
6 in demonstration programs that are developed  
7 through planning grants awarded under subsection  
8 (c), meet the requirements of this subsection, and  
9 represent a diverse selection of geographic areas, in-  
10 cluding rural and underserved areas.

11 (2) APPLICATION REQUIREMENTS.—

12 (A) IN GENERAL.—The Secretary shall so-  
13 licit applications to participate in demonstration  
14 programs under this subsection solely from  
15 States awarded planning grants under sub-  
16 section (c).

17 (B) REQUIRED INFORMATION.—An appli-  
18 cation for a demonstration program under this  
19 subsection shall include the following:

20 (i) The target Medicaid population to  
21 be served under the demonstration pro-  
22 gram.

23 (ii) A list of participating certified  
24 community behavioral health clinics.

1 (iii) Verification that the State has  
2 certified a participating clinic as a certified  
3 community behavioral health clinic in ac-  
4 cordance with the requirements of sub-  
5 section (b).

6 (iv) A description of the scope of the  
7 mental health services available under the  
8 State Medicaid program that will be paid  
9 for under the prospective payment system  
10 tested in the demonstration program.

11 (v) Verification that the State has  
12 agreed to pay for such services at the rate  
13 established under the prospective payment  
14 system.

15 (vi) Such other information as the  
16 Secretary may require relating to the dem-  
17 onstration program including with respect  
18 to determining the soundness of the pro-  
19 posed prospective payment system.

20 (3) NUMBER AND LENGTH OF DEMONSTRATION  
21 PROGRAMS.—Not more than 8 States shall be se-  
22 lected for 4-year demonstration programs under this  
23 subsection.

24 (4) REQUIREMENTS FOR SELECTING DEM-  
25 ONSTRATION PROGRAMS.—

1 (A) IN GENERAL.—The Secretary shall  
2 give preference to selecting demonstration pro-  
3 grams where participating certified community  
4 behavioral health clinics—

5 (i) provide the most complete scope of  
6 services described in subsection (a)(2)(D)  
7 to individuals eligible for medical assist-  
8 ance under the State Medicaid program;

9 (ii) will improve availability of, access  
10 to, and participation in, services described  
11 in subsection (a)(2)(D) to individuals eligi-  
12 ble for medical assistance under the State  
13 Medicaid program;

14 (iii) will improve availability of, access  
15 to, and participation in assisted outpatient  
16 mental health treatment in the State; or

17 (iv) demonstrate the potential to ex-  
18 pand available mental health services in a  
19 demonstration area and increase the qual-  
20 ity of such services without increasing net  
21 Federal spending.

22 (5) PAYMENT FOR MEDICAL ASSISTANCE FOR  
23 MENTAL HEALTH SERVICES PROVIDED BY CER-  
24 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-  
25 ICS.—



1 (A) IN GENERAL.—The Secretary shall pay  
2 a State participating in a demonstration pro-  
3 gram under this subsection the Federal match-  
4 ing percentage specified in subparagraph (B)  
5 for amounts expended by the State to provide  
6 medical assistance for mental health services  
7 described in the demonstration program appli-  
8 cation in accordance with paragraph (2)(B)(iv)  
9 that are provided by certified community behav-  
10 ioral health clinics to individuals who are en-  
11 rolled in the State Medicaid program. Payments  
12 to States made under this paragraph shall be  
13 considered to have been under, and are subject  
14 to the requirements of, section 1903 of the So-  
15 cial Security Act (42 U.S.C. 1396b).

16 (B) FEDERAL MATCHING PERCENTAGE.—  
17 The Federal matching percentage specified in  
18 this subparagraph is with respect to medical as-  
19 sistance described in subparagraph (A) that is  
20 furnished—

21 (i) to a newly eligible individual de-  
22 scribed in paragraph (2) of section 1905(y)  
23 of the Social Security Act (42 U.S.C.  
24 1396d(y)), the matching rate applicable  
25 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,

1 or any other non-ambulatory services,  
2 as determined by the Secretary; or

3 (II) with respect to payments  
4 made to satellite facilities of certified  
5 community behavioral health clinics if  
6 such facilities are established after the  
7 date of enactment of this Act.

8 (6) WAIVER OF STATEWIDENESS REQUIRE-  
9 MENT.—The Secretary shall waive section  
10 1902(a)(1) of the Social Security Act (42 U.S.C.  
11 1396a(a)(1)) (relating to statewideness) as may be  
12 necessary to conduct demonstration programs in ac-  
13 cordance with the requirements of this subsection.

14 (7) ANNUAL REPORTS.—

15 (A) IN GENERAL.—Not later than 1 year  
16 after the date on which the first State is se-  
17 lected for a demonstration program under this  
18 subsection, and annually thereafter, the Sec-  
19 retary shall submit to Congress an annual re-  
20 port on the use of funds provided under all  
21 demonstration programs conducted under this  
22 subsection. Each such report shall include—

23 (i) an assessment of access to commu-  
24 nity-based mental health services under the  
25 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 Federal 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;

1 RURAL HEALTH CLINIC SERVICES; RURAL HEALTH  
 2 CLINIC.—The terms “Federally-qualified health cen-  
 3 ter services”, “Federally-qualified health center”,  
 4 “rural health clinic services”, and “rural health clin-  
 5 ic” have the meanings given those terms in section  
 6 1905(l) of the Social Security Act (42 U.S.C.  
 7 1396d(l)).

8 (2) ENHANCED FMAP.—The term “enhanced  
 9 FMAP” has the meaning given that term in section  
 10 2105(b) of the Social Security Act (42 U.S.C.  
 11 1397dd(b) but without regard to the second and  
 12 third sentences of that section.

13 (3) SECRETARY.—The term “Secretary” means  
 14 the Secretary of Health and Human Services.

15 (4) STATE.—The term “State” has the mean-  
 16 ing given such term for purposes of title XIX of the  
 17 Social Security Act (42 U.S.C. 1396 et seq.).

18 (f) FUNDING.—

19 (1) IN GENERAL.—Out of any funds in the  
 20 Treasury not otherwise appropriated, there is appro-  
 21 priated to the Secretary—

22 (A) for purposes of carrying out sub-  
 23 sections (a), (b), and (d)(7), \$2,000,000 for fis-  
 24 cal year 2014; and

1 (B) for purposes of awarding planning  
 2 grants under subsection (c), \$25,000,000 for  
 3 fiscal year 2016.

4 (2) AVAILABILITY.—Funds appropriated under  
 5 paragraph (1) shall remain available until expended.

6 **SEC. 416. ANNUAL MEDICAID DSH REPORT.**

7 Section 1923 of the Social Security Act (42 U.S.C.  
 8 1396r-4) is amended by adding at the end the following:

9 “(k) ANNUAL REPORT TO CONGRESS.—

10 “(1) IN GENERAL.—Beginning January 1,  
 11 2015, and annually thereafter, the Secretary shall  
 12 submit a report to Congress on the program estab-  
 13 lished under this section for making payment adjust-  
 14 ments to disproportionate share hospitals for the  
 15 purpose of providing Congress with information rel-  
 16 evant to determining an appropriate level of overall  
 17 funding for such payment adjustments during and  
 18 after the period in which aggregate reductions in the  
 19 DSH allotments to States are required under para-  
 20 graphs (7) and (8) of subsection (f).

21 “(2) REQUIRED REPORT INFORMATION.—Ex-  
 22 cept as otherwise provided, each report submitted  
 23 under this subsection shall include the following:

24 “(A) Information and data relating to  
 25 changes in the number of uninsured individuals

1 for the most recent year for which such data  
2 are available as compared to 2013 and as com-  
3 pared to the Congressional Budget Office esti-  
4 mates of uninsured individuals made at the  
5 time of the enactment of the Patient Protection  
6 and Affordable Care Act (Public Law 111–148)  
7 and the Health Care and Education Reconcili-  
8 ation Act of 2010 (Public Law 111–152).

9 “(B) Information and data relating to the  
10 extent to which hospitals continue to incur un-  
11 compensated care costs from providing unreim-  
12 bursed or under-reimbursed services to individ-  
13 uals who either are eligible for medical assist-  
14 ance under the State plan under this title or  
15 under a waiver of such plan or who have no  
16 health insurance (or other source of third party  
17 coverage) for such services.

18 “(C) Information and data relating to the  
19 extent to which hospitals continue to provide  
20 charity care and unreimbursed or under-reim-  
21 bursed services, or otherwise incur bad debt,  
22 under the program established under this title,  
23 the State Children’s Health Insurance Program  
24 established under title XXI, and State or local  
25 indigent care programs, as reported on cost re-

ports 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



1           have multiple other missions, such as a commit-  
 2           ment to graduate medical education, the provi-  
 3           sion of tertiary and trauma care services, pro-  
 4           viding public health and essential community  
 5           services, and providing comprehensive, coordi-  
 6           nated care.

7           “(G) Such other information and data rel-  
 8           evant to the determination of the level of fund-  
 9           ing for, and amount of, State DSH allotments  
 10          as the Secretary determines appropriate

11          “(3) AUTHORIZATION OF APPROPRIATIONS.—  
 12          There is authorized to be appropriated to the Sec-  
 13          retary for the period of fiscal years 2015 through  
 14          2109, such sums as may be necessary to carry out  
 15          this subsection.”.

16 **SEC. 417. IMPLEMENTATION.**

17          To the extent the Secretary of Health and Human  
 18          Services issues a regulation to carry out the provisions of  
 19          this Act, the Secretary shall, unless otherwise specified in  
 20          this Act—

- 21               (1) issue a notice of proposed rulemaking that
- 22               includes the proposed regulation;
- 23               (2) provide a period of not less than 60 cal-
- 24               endar days for comments on the proposed regula-
- 25               tion;

1           (3) not more than 24 months following the date  
2           of publication of the proposed rule, publish the final  
3           regulation or take alternative action (such as with-  
4           drawing the rule or proposing a revised rule with a  
5           new comment period) on the proposed regulation;  
6           and

7           (4) not less than 30 days before the effective  
8           date of the final regulation, publish the final regula-  
9           tion or take alternative action (such as withdrawing  
10          the rule or proposing a revised rule with a new com-  
11          ment period) on the proposed regulation.

12                   **TITLE V—RESTORING**  
13                   **INDIVIDUAL LIBERTY**

14   **SEC. 501. RESTORING INDIVIDUAL LIBERTY.**

15          Sections 1501 and 1502 and subsections (a), (b), (c),  
16          and (d) of section 10106 of the Patient Protection and  
17          Affordable Care Act (and the amendments made by such  
18          sections and subsections) are repealed and the Internal  
19          Revenue Code of 1986 shall be applied and administered  
20          as if such provisions and amendments had never been en-  
21          acted.



Calendar No. 330

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

**S. 2122**

**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 13, 2014

Read the second time and placed on the calendar